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THE JOURNAL OF CUTANEOUS DISEASES
INCLUDING SYPHILIS

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THE JOURNAL OF CUTANEOUS DISEASES

VOL. XXVI AUGUST NO. 8

THE OCCURRENCE OF A PROLIFERATING CESTODE LARVA (SPARGANUM PROLIFERUM) IN MAN IN FLORIDA.[1]

By Ch. Wardell Stiles, Ph. D., D. Sc.

Chief Division of Zoology, Hygienic Laboratory, U. S. Public Health and Marine Hospital Service.

Medical history of the case.—In June of this year, I received from Dr. H. Gates, of Manatee, Florida, specimens of worms, for identification, which he had taken from the skin of man. The following extracts from Doctor Gates' letters give all that is known to me regarding the medical history of the case. In connection with this history, it will be well to abstract in considerable detail on account of a very similar case recently reported by Ijima (1905) in Tokyo, Japan.

Gates' case.—"Enclosed find specimens of worms from human flesh. They are inclosed in sacks deep under the skin in the connective tissue. My patient has thousands of them, all over the trunk; they can be seen and felt as nodules; deeper in the connective tissue in the left groin and left breast, there seem to be large masses of them. I send some I obtained by cutting open the nodules and squeezing them out, and others still in the cyst as I found them."—From letter dated June 17, 1907.

"In reply to your request for history, etc., of patient (J. W. M.), infected with larval tapeworm, I would state that I first discovered the condition in April of this year. I was called in to treat him for dysentery. While examining over abdomen, I found a great many nodules in the skin, and also in the fascia between the skin and the muscles. Deep down in the abdominal cavity, I found large and small tumors, some moveable, and others fixed by adhesions. All the lymphatic glands on the side most infected were enlarged and in masses, as if they had formed close union with surrounding tissue.

"The muscles were exempt from nodules, but soft and flabby.

[1] Read before the Sixth International Dermatological Congress, New York, September 9-11, 1907.

I opened one nodule near the surface and obtained two worms. Most of the nodules on the skin are about the size and shape of grains of rice. When they first appear there is an itching produced. The cyst is filled with a clear watery fluid in which is found the small worm. In a few days a cyst wall is formed, surrounding the worm which lies in a jelly- or slime-like substance. After weeks or months the cyst wall becomes firm, and surrounds one or more worms. In some cysts I have found as many as three worms. In the course of a few months the cyst wall breaks and there is nothing left, but, sometimes, a blue spot showing a small hemorrhage; after this is absorbed, there will be only a spot of indurated tissue to mark the place. The places that have been infected the longest appear as a mass of indurated skin and fascia closely connected, so that the skin can be picked up only with the mass of worms and tissue.

"Patient is now forty-eight years old. He came to Florida in 1872 from Minnesota and settled with his father on a point on the Manatee River, now known as Mann's Point, which was accessible to fish and oysters.

"When twenty-three years old, while hunting in the woods about 1½ miles from the coast, he noticed a small pimple on the left shoulder, which attracted his attention because of the itching. He thought the skin had been punctured by a thorn. He squeezed the lump, from which came a small flat worm about 1-16 inch wide and 5-8 inch long. One year after the first appearance on the shoulder, he noticed four or five small lumps on his chest: these he opened with a knife and he picked out the same kind of worms; these swellings also had produced an itching sensation. Patient was then living as fisherman on Sarasota Bay.

"While fishing, patient's diet consisted of smoked and dried fish, raw oysters, scallops, and clams. Up to five or six years ago he was a robust, healthy specimen of manhood, but lacked energy. At present he has a tired expression, has less energy, and becomes exhausted after little exertion.

"From the photographs, you will see enlargement of the left breast and shoulder, also of left groin and lumbar region. Spleen and liver are enlarged.

"The infection is slight on the right side.

"Patient has a wife and five children, all of whom are healthy.

"There probably was another case similar to this a few years ago, in this county. I have been trying to obtain a history of it, but have failed thus far. The man moved from here to California,

where he died. The report was that he was eaten up with worms before he died."—Extracts from letter, August, 1907.

Japanese case.—The patient was a Japanese woman, Yae Tanaka by name, resident in Tokyo or immediate vicinity. Before her marriage to a dealer in old furniture, she was a weaver, "occupations which place her decidedly in the lower class of society."

At the age of thirty-three years, in the spring of 1904, she visited the University Hospital at Tokyo, for treatment for left inguinal hernia, entering the surgical wards of Dr. J. Kondo. This hernia was traceable to the presence of parasites in the region of Ligamentum poupartii. In addition to the hernia, she presented a peculiarly swollen condition of the integument which bore scattered spots of acne-like appearance. This abnormal condition extended over nearly the entire body, except on the face and upper extremities; it was most prominent on the left thigh which was greatly swollen and presented very much the appearance of elephantiasis, although the skin and underlying tissues were quite soft, so that they hung down by their own weight and could be grasped in a flaccid mass by the hand.

When twenty-five years old, the patient had a tapeworm, the species of which is not known. The dermal affection was first felt when she was thirty-one years old, so that at time of entrance to hospital it was of about two years standing. It had given no particular trouble beyond that imposed upon motion by the swollen thigh, and the itching of the skin in parts where a pimple-like hardening made its appearance; scratching with the nails, in order to allay the itching, had led to breaking the skin, from which a soft whitish mass, together with some fluid, could be pressed out. A number of resulting recent scars, especially on the breasts, were visible.

In preparations, made of skin taken from the left thigh, Ijima became convinced of the presence, in the connective tissue, of numerous encapsuled worms, the cestode nature of which was recgnized from the calcareous corpuscles.

On each of two subsequent occasions, July 9th and 24th, 1904, a very large piece of skin, with the underlying connective tissue, was excised from the left thigh, in order to relieve the patient of the superfluous tissue. Altogether, several pounds in weight were removed during patient's stay at the hospital.

When freshly excised, the subcutaneous tissues presented an unusual appearance. At places several centimeters thick, they were

moderately rich in panniculus adiposus and extraordinarily rich in lymph; the latter swelled the connective tissue between the panniculi, giving it a slimy or gelatinous appearance and consistency; the slimy character seemed more manifest in the deeper parts; lymph exuded copiously from the cut surfaces; numerous capsules, with the contained worm, were observable as whitish objects, isolated or in clusters, in all parts of the tissues. The thickness of tissues between the surface and the underlying tissue measures 30 to 60 mm., notwithtanding the fact that the hardening process has contracted the subcutaneous connective tissue, through loss of the lymph, into dense fibrous bundles, so that it no longer bears a resemblance to what it was in the fresh state. The corium in the same piece may be said to be 3 to 6 mm. thick; it seems to be on the whole considerably thicker than in the normal state.—Abstracted from Ijima, 1905.

Further medical details are not given by Ijima, but he states that Professor Kondo will publish a report of clinical and pathological observations. I have not as yet learned of the publication of the report in question.

From the foregoing abstracts, the suspicion immediately arises that in Florida we have a skin infection, hitherto unrecognized for the American continent, and similar to, perhaps identical with, an infection recognized only on one former occasion, namely in Japan.

It is interesting to note the following comparison in the cases, without laying too much stress upon these points at present:

Both cases occurred near the eastern shore of the continents in question (Old World, between 35° and 36° N; and New World, between 27° and 28° N.); both patients lived in cities or towns located directly on the water, very near larger bodies of water (Pacific Ocean and Gulf of Mexico); both patients, though of different sex, were adult (twenty-three years male, thirty-one years female) when the infection was first noticed; both patients belonged to the poorer classes of society; one had a professedly fish diet, the other lives in a country where a fish diet is very common; both infections are of long standing (in one case over three years, in the other case about twenty-five years); in both cases the number of individual worms present was very great; both observers (Ijima for Japan, and Gates for Florida), independently call attention to the acne-like lesion resulting from the infection; each patient is a native of the country in which the case was found, and in neither case is there any history given of the patient's having visited the country of the other patient.

Nature of the parasite.—A microscopic examination of the

worms forwarded by Doctor Gates showed them to contain calcareous corpuscles, hence the diagnosis of cestode infection was immediately established in this case on the same basis as was the diagnosis in the Japanese case. The cestode in question is a larval form, without suckers on the head, and, as far as seen, without any primordium of genital organs. The most striking feature of the worm is its irregular shape, with tendency to proliferation by forming supernumerary heads. These characters immediately bring up for consideration the question as to whether the worm found by Gates is identical with the parasite recently reported by Ijima (1905) for Japan. As the American and the Japanese parasites are very closely related, possibly specifically identical, it will be well to follow the two in comparison. In doing this, it will be advisable to abstract Ijima's paper rather liberally, more especially since it is published in a journal not generally accessible to dermatologists.

The worm capsule of Ijima's parasite.—Ijima (1905, 4-5) states that the worm capsules of various sizes occur in abundance in all parts of the subcutaneous tissues, and less abundantly in the corium. They were also observed in some numbers in the intermuscular connective tissue, but not in the muscles themselves, so far as such observation could be made on parts incidentally exposed during the surgical operation. In the corium, the capsule may be situated so close to the epidermis that the latter is externally raised into an acne-like prominence. On a piece of the preserved skin, about two inches square, Ijima found at least four such prominences, which as seen on the surface, appear smooth and less pigmented than the surrounding parts. Capsules so superficially situated might easily be ruptured by force applied through the skin from without.

In shape, the capsules are generally subspherical or ovoid. While the smallest of them are considerably less than 1 mm., others measuring 1 to 2 mm. or more are of quite common occurrence; one of the largest seen was elongate, 2.5 mm. broad, by 8 mm. long; another measured 3 mm. by 6 mm. The larger capsules were found only in the subcutaneous parts; not in the corium.

The capsular wall, consisting of a dense felt-work of connective tissue fibers of the host, may reach nearly 0.33 mm. in thickness; in sections the capsules may appear not unlike a transversely cut blood-vessel on account of the tough and compact looking wall; under a hand-lens, the inner surface of the capsule appears smooth; in some of the larger cysts, the internal cavity is traversed by branching trabeculæ; microscopically, the wall either shows no special limiting

structure, or is lined with a deposit of granular coagulum or tissue debris.

Abundance of parasite.—In Doctor Gates' letter of June 17, he states that his "patient has thousands of" these parasites.

In the Japanese case, a section of about 11 sq. cm. showed nearly 60 capsules; in the most thickly infested portions of the thigh, there was 1 capsule to every 20 sq. mm. of cut surface, or to every 100 cu. mm. of infested tissue; this gives 1000 capsules per 100 cu. cm. of tissue. It was estimated that there must have been considerably over 10,000 capsules in the left thigh alone.

Worms without capsules.—Scarcely any of the worms Gates forwarded to me bore any remnant of the cyst. Very probably most of these specimens were originally encysted and were freed from their cyst by Doctor Gates before he forwarded them.

Comparatively young, slender worms were found by Ijima free in the connective tissue, that is, not surrounded by a capsule.—Ijima, 1905.

Movements of the worm.—Not having seen the worm alive, I can give no details regarding movements.

Ijima reports that the living worms when taken from the patient, showed slow movements of extension and contraction, but effecting little or no change in position; upon cooling, the worms no longer exhibited such movements; in case of worms placed in salt solution, motion could be revived, up to a period of four hours, if the parasites were slightly warmed.

The head (narrow end) was the most motile, evaginating and invaginating at the apex, in addition to shortening and extending; the terminal, but inconstant, depression in some cases, reminded the observer of a terminal sucker, such as seen in the fish bothriocephalid *Cyathocephalus*. In addition to a motion as if feeling about, the head started a lively peristalsis, from before backward; such combined movements would aid the worm in penetrating and moving through tissues.

The broader parts of the body showed at most slow vermiform movements, with more or less constant indentation at the extreme hind end.

The head.—Ijima states that the head of his parasite is devoid of any definitely formed or permanent organ of attachment. This holds true also for the worm found by Gates. In some few specimens a slight apical depression is observed, but as the material is preserved in alcohol, this might possibly be either an artifact or a depression due to sudden contraction on the part of the worm.

PLATE XXVIII.—To Illustrate Dr. Ch. W. Stiles' Article.

Fig. 1.

Fig. 2.

Fig. 3.

Fig. 4.

PLATE XXIX.—To Illustrate Dr. Ch. W. Stiles' Article.

Fig. 5.

Fig. 6.

Fig. 7.

Encysted worms.—Gates writes that he found as many as three worms in one cyst. This condition is doubtless due, as Ijima explains also for his case, to the tendency of the worm to multiply by budding.

Ijima reports that the smaller capsules usually contained only a single worm; in the larger cysts, however, two or more worms or pieces were more frequently found; from one capsule, 5 worms were obtained, and from another, 7 worms.

Size and shape.—The longest specimen I have observed is 12 mm. in length. Some of the worms are simple elongated bodies, either more or less flattened, or nearly round in transverse section. The larger specimens, however, assume all manner of bizarre and irregular shapes which cannot be well described. These variations in form may be reduced to a progressive, but irregular formation of buds, the apex of each bud representing a structure similar to the cephalic end of the original worm; the form varies, of course, according to the number, position, contraction, etc., of the buds, and according to the contraction of the parent stock. Figs. 5 to 15 will give an idea of the great variety of forms found.

According to Ijima, many of the worms are small, filiform, about 0.3 mm. in diameter, 3 mm. in length; others attain, even when moderately contracted, 12 mm. long by 2.5 mm. broad. In some specimens, the body is flattened, dorso-ventrally, but there is no clew to which is dorsal and which is ventral surface. In its simplest form, the worm is plerocercus-like, or narrow at the head and broader caudad, when moderately contracted, or irregularly cylindrical when strongly contracted.

This simple plerocercus-like larva, when encysted, may assume a rather complicated structure, due to its ability to form buds or supernumerary heads, especially on the lateral edges of the flattened body in younger specimens, but quite irregularly in the more complicated older forms. When the heads detach themselves, they represent small independent plerocercus-like larvæ, and their method of formation explains the presence of several worms in one cyst.

The formation of heads, in the manner prescribed, naturally tends to give the worms a very irregular outline: this irregularity is increased by the formation of subcuticular bodies which Ijima interprets as food material. Ijima assumes that these young heads leave the capsule and wander through the connective tissue until they grow in size and then in turn form a capsule of their own.

Microscopic anatomy.—According to Ijima, the cuticule of the

Japanese form may attain 8 mm. in thickness; the dermal musculature consists of external circular and internal longitudinal fibers. These statements are correct as applied to the Florida form also.

The *calcareous corpuscles* of the Japanese worm are described by Ijima as spherical or ellipsoidal, 7.5 to 12 mm. in diameter, and abundant in all parts of the parenchyma except in the head, in which they are lacking. In the Florida form also, the calcareous corpuscles are abundant; they vary in size from 8.8 mm. to 17.6 mm.; in shape they are spherical to ellipsoidal. Thus, in reference to the size of the calcerous corpuscles, there seems to be a slight difference between the American and the Japanese parasites.

Reserve food bodies.—Ijima has described as present in the parenchyma, certain bodies which he views as reserve food material. Usually they are roundish or oval, 100 to 300 mm. in diameter; but they may become elongate and very long.

In the Florida parasite, similar bodies are present, but in the specimens thus far examined microscopically, they do not seem to be quite so numerous or quite so large and prominent as described by Ijima for the Japanese form. It is possible, however, that this is a matter of individual variation.

Excretory system.—The parasites as described by Ijima contain an extensive system of anastomosing excretory vessels. In this respect the Florida form agrees with the Japanese species. Some of the canals are quite large, others are smaller, some are very small. Ijima calls attention to the absence of excretory vessels in the peripheral zone of the posterior part of the body; he also states that he was unable to find any opening.

In sections of one of the Florida parasites, fine canals were found rather close to the cuticle, but because of the branched condition of the worm it is difficult to state just what portion of the body this was; it was not, however, a head. Likewise, in one case, sections of a pore (Fig. 18) on the surface, with a centripetally directed canal were distinctly seen. In view of the absence of genital organs, one is naturally inclined to look upon this pore as belonging to the excretory system.

The longitudinal *muscles* of the Japanese worm are described as well developed, and in addition there is a less strongly developed set of muscle fibers running in different directions but mainly in the transverse plane. Near the head, these transverse muscles may be quite regular (some dorso-ventral, others crossing these at right angles), but in thicker portions of the body, they may become very

irregular. This description applies in a general way to the Florida form also.

Nervous system.—Ijima noticed a pair of longitudinal, lateral nerve trunks in the cephalic portion; they seemed to unite close to the tip of the head. In several sections of the Florida worms, nerves were distinguished, but details as to their topography were not studied.

Life cycle.—Experiments to raise the adult stage by feeding the Japanese parasites to cats, dogs, and pigs, were negative.

As all of my own material was preserved, no experiments could be undertaken. The question as to the source of infection, life cycle, etc., must be left open for the present.

Systematic position.—From the general structure, especially from the presence of calcareous corpuscles, it is clear that both the Japanese and the Florida parasites are cestodes; the absence of suckers seems to place both forms in the old family Bothriocephalidæ, now known as Dibothriocephalidæ. Further than this, the exact systematic position is not clear at present and can not well be determined until the adult stage is known.

So far as can be judged from the material thus far studied (prior to the meeting of the International Dermatological Congress in New York, Sept. 9, 1907), the Florida form must be considered as very closely allied to, perhaps specifically identical with, the Japanese form. The only anatomical point of difference thus far brought out is a difference in size of the calcareous corpuscles; the only biological difference known is the habitat—in two widely separated localities.

Ijima points out the structural affinities between the Japanese form and the bothriocephalid larval *Sparganum* of Diesing; he refers also to the similarity between the Japanese form and "*Ligula mansoni*" (*Sparganum mansoni*).

Sparganum is an artificial collective group of worms, distinctly proposed not as a systematic unit, but as a collective group of larval bothriocephalid cestodes. Under the International Code of Nomenclature (1907), such names may be proposed as a matter of convenience and may be used as if they were generic names: they do not require any type species and hence do not compete with generic names under the Law of Priority.

Both the Japanese and the American parasite may be temporarily classified in *Sparganum*.

The Japanese worm was originally published under the two

names *Plerocercoides prolifer* and *Plerocercus prolifer*, but Ijima distinctly states that he uses the names as a matter of convenience, namely, not in a taxonomic sense. Certain objections arise, however, to the use of the names *Plerocercus* and *Plerocercoides* in this connection and on this account I transferred (1906a) the parasite to *Sparganum*.

The nomenclatural points involved are somewhat complex and it may be well to explain them in this place.

Under the original International Code, the names of larval cestodes, and of certain other forms, were for special reasons exempted from the Law of Priority. Later (1901) contrary to the judgment of helminthologists, this exemption was done away with.

To apply the Law of Priority consistently to all such larval names would be almost an impossibility. There are, in fact, many names which have been proposed, not in a generic sense, but as names of admittedly artificial groups which were used simply as a matter of temporary convenience, and it was on account of a failure to distinguish between names of this category and names proposed for supposed genera, that the exception was rescinded. In 1907, at the Boston Congress, an helminthologist proposed the following, which was adopted as part of the Code:

"Certain biological groups which have been proposed distinctly as collective groups, not as systematic units, may be treated for convenience as if they were genera, but they require no type species. Examples: *Agamodistomum*, *Amphistomulum*, *Agamofilaria*, *Agamomermis*, *Sparganum*."

As will be shown below, *Plerocercus* and *Plerocercoides* also now come under this paragraph. As matters now stand, it is necessary to show that a name was distinctly proposed to designate an artificial collective group in order to bring it under this provision. A name like *Cysticercus* or *Echinococcus*, originally proposed as generic, not distinctly to cover an admittedly artificial group, is subject, now as before, to the Law of Priority.

The term *Plerocercus* (πλήρης, full; κέρκος, tail) was proposed by Braun (1883a, 98) as designation for the parenchymatous cysticerci (namely, those the caudal portion of which contains no fluid) as distinguished from the bladder worms, or true cysticerci; thus, it is a descriptive term for a stage of development (larva) possessing certain characters, but not the designation of a systematic unit. As examples, Braun cited a *Plerocercus* (*Dithyridium lacertæ* Val.) of lizards and a *Plerocercus* of *Tetrarhynchus*. The

PLATE XXX.—To Illustrate Dr. Ch. W. Stiles' Article.

FIG. 8.

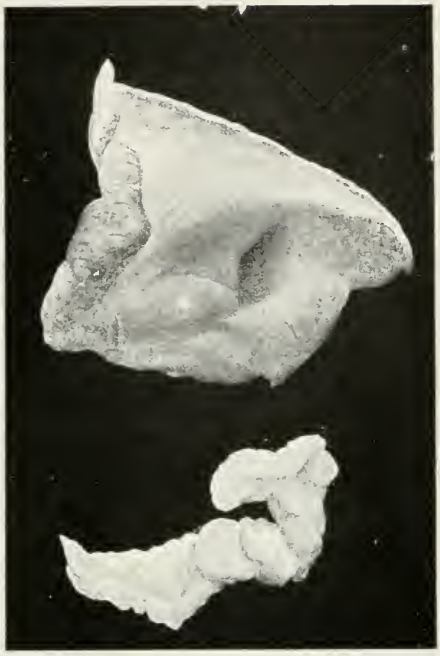

FIG. 9.

FIG. 10.

PLATE XXXI.—To Illustrate Dr. Ch. W. Stiles' Article.

Fig. 11.

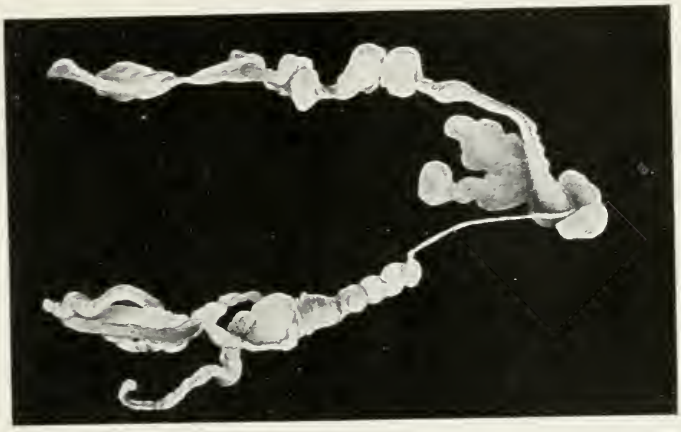

Fig. 12.

Fig. 13.

plerocercus of the lizards happens to figure in a true nomenclatural sense, namely in the genus

DITHYRIDIUM Rudolphi, 1819

1819: *Dithyridium* Rud., 1819a, 559 (*lacertæ viridis, lacertæ muralis;* Europe. Type by later absolute tautonymy *Piestocystis dithyridium=Dith. lacertæ*).

1850: *Piestocystis* Dies., 1850a, 478, 494-496 (*Dithyridium* 1819, renamed; includes as valid species *P. crispa*

In 1866, Baillet mentioned a parenchymatous cysticercus (Rud.), *P. rugosus* Dies., *P. variabilis* Dies., *P. dithyridium* Dies., (for *Dithyridium* of Rud., namely, *D. lacertæ* Valenciennes, 1844).

This genus is based upon a larval tapeworm (a plerocercus) provided with four suckers, and is classified in the family *Tæniidæ*; the type species occurs in Europe in lizards of the genus *Lacerta.* (namely, a plerocercus) from the abdominal cavity of the cat and dog. In 1882 or 1883, Blumberg described this form as a new species under the name *Cysticercus elongatus*; the latter name, however, was already preoccupied (cf. *C. elongatus* Leuck., 1842). In 1885, Railliet renamed this form *Cysticercus bailleti*,, and in 1893a, p. 314, he classified it in the genus *Dithyridium* as *D. elongatum.* In the meantime, however, Neumann (1892a, 537-539, Figs. 292-293) referred to the same parasite as "*Plerocercoides bailleti*," clearly using a Latin binominal nomenclature.

The name *Plerocercoides* as used by Neumann is traceable to Braun (1882a, 100), who used a German term "Plerocercoiden" to designate certain larval forms which differed from the cysticercoids by having parenchymatous tails; as examples Braun cites a form which occurs in the body cavity of *Trichodectis canis,* and the young (*Gyporhynchus*) of *Tænia macropeos* and *T. unilateralis.* Blanchard (1888a, 491) used a French form (*Plérocercoides*) of the word, while Neumann (1892a, 537) seems to have first used the Latin *Plerocercoides.* From Neumann's text, however, it is clear that he based his name on Braun's "Plerocercoiden," hence Neumann's *Plerocercoides* is not a generic name but the designation of an artificial collective group, hence also the type designation (*bailleti*) suggested by myself in 1906 is not necessary under the new (1907) Code.

As a plerocercus may be the larval form of species belonging

to widely distinct families, even to different orders, it is wise not to use the combination *Plerocercus prolifer* in case a better designation is available; this point probably occurred to Ijima, for he used the combination only once. *Plerocercoides* is also open to the same objection, and in the only use of the term prior to Ijima, it was used for a *Dithyridium*.

It so happens that Diesing proposed a name which is open to fewer objections. This is the

Collective Group Sparganum Diesing, 1850.

Diagnosis.—*Dibothriocephalidæ*: An artificial collective group to contain larval stages of bothriocephalid worms, which have not reached a stage in their development that they can be determined generically.

Such groups do not require a type species.

In 1906, I placed Ijima's form in this group as the proliferating

The Proliferating Japanese Tapeworm Larva—(Ijima, 1905) Stiles, 1906—Sparganum Proliferum.

Specific Diagnosis.—*Sparganum:* Larva may attain 1 to 12 mm. in length and 2.5 mm. in breadth; head narrower and more motile than posterior end, and may show an apical depression which, perhaps, serves as sucker; no true suckers or other organs of attachment present. Calcareous corpuscles spherical or ellipsoidal, 7.5 to 12 mm. (Japanese worm) or 8.8 to 17.6 mm. (Florida worm) in diameter, and situated in any part of body except head; irregularly distributed reserve food bodies present in older specimens, but they later undergo disintegration; genital organs not present; longitudinal muscles better developed than either dorso-ventral or transverse system; transverse fibers do not divide body into cortical and medullary layers; excretory system well developed, consisting of larger approximately longitudinal branches, with anastomeses. The larvæ possess the power of multiplying by transverse fission and of forming supernumerary heads which may become independent. Adult unknown.

Habitat.—Encysted in subcutaneous tissue and elsewhere in man.

Geographical Distribution.—Found but twice; once by Ijima in Tokyo, Japan; once by Gates in Manatee, Florida.

Whatever results may be obtained from examination of further

material, which I could not study prior to the meeting of this Dermatological Congress, at the present time I do not feel justified in separating the American form specifically from the Japanese species, despite the difference in geographic distribution and the slight difference in the calcareous corpuscles. That the adult stage may eventually prove the Florida form to represent a distinct species, seems entirely possible; in fact, when we consider the seeming isolation of the two cases, this appears probable. At the same time, if it should eventually be shown that the infection was contracted from eating marine fish, the possibility would not be excluded that the two forms are identical, despite the wide difference in locality. In the interest of conservatism, accordingly, I classify, for the present, the two in the same species.

In an earlier paper (1906a, 86) I called attention to the fact that because of the remarkable reproduction of the larval stage described by Ijima, a new genus would probably be justified. I hesitated somewhat to make the genus without seeing actual specimens. After examining the American specimens, I am further convinced of the probability that the worm in question represents a new genus.

The proposition of a new generic name at this time, presents both advantages and disadvantages. To continue to call the worm *Sparganum* shows that the family position is recognized, but that the adult is unknown; the worm is, however, so different from the other forms of *Sparganum* that it seems advisable to bring out this difference in a generic name; further, as long as a new generic name seems almost inevitable, it would appear wise to introduce it as soon as possible, in order to reduce its competition (through homonymy) in the future. On the other hand, to introduce a new combination at present, does not seem absolutely necessary; its introduction would destroy the advantages we have at present in the use of the name *Sparganum*.

There is, I believe, a conservative method by which the advantages of both plans may be united, namely, by the introduction of a new subgeneric name.This course permits the continuation of the use of the name *Sparganum*, and at the same time brings out the fact that the worm is very different from the other forms of *Sparganum*; further, it procures for the name any advantages in homonymy which may be gained by its proposal this year instead of later.

As such subgeneric name, I propose——

GATESIUS[1] n.subg.

Diagnosis.—*Dibothriocephalidæ, ? Ligulinæ*, classified temporarily in *Sparganum*. Adult unknown. Larva, in its simplest form similar to the plerocercus of *Dibothriocephalus* except for suckers, which are absent; possesses the property of branching, and of reproducing by budding, thus forming supernumerary heads which become free from parent and assume the simple plerocercoid form. Body contains numerous calcareous corpuscles, richly developed canal system, and may contain reserve food bodies.

Type species.—*Spargarnum* (*Gatesius*) *proliferum* (*Ijima*, 1905) Stiles, 1907, from connective tissue of man; Japan.

It will be noticed that from the form of this proposal, the name *Gatesius* is proposed not as a collective group, similar to *Sparganum*, but as a true systematic name of subgeneric rank. When the adult form becomes known, the species should be taken out of the group *Sparganum* and this subgenus raised to generic rank.

All drawings made by Leonard H. Wilder.

DESCRIPTION OF PLATES.

Figs. 1-4.—Four photographs of Gates' patient in Florida, showing acne-like condition and enlarged breasts due to infection with *Sparganum proliferum*. (Original; photos kindly furnished by Doctor Gates.)

Fig. 5.—*Sparganum proliferum*, in part in a cyst. Original X. 10.

Fig. 6.—*Sparganum proliferum*, escaped from the cyst. Original X. 10.

Figs. 7-15.—Nine specimens of *Sparganum proliferum*, showing various forms, buds, and supernumerary heads. Original X. 10.

Fig. 16.—Section through a cyst, with the escaped *Sparganum proliferum*. Original. Greatly enlarged.

Fig. 17.—Section through the reserve food particle (see x., fig. 16). Original. Greatly enlarged.

Fig. 18.—Section showing: large excretory canal, smaller canals, calcareous corpuscles, and a pore. Original. Greatly enlarged.

[1] Dedicated to Dr. H. Gates, of Manatee, Florida, who found the first American case.

PLATE XXXII.—To Illustrate Dr. Ch. W. Stiles' Article.

Fig. 14.

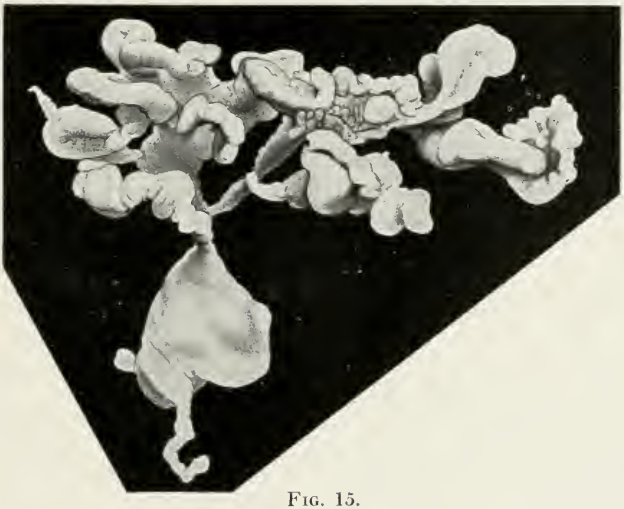

Fig. 15.

Fig. 16.

PLATE XXXIII.—To Illustrate Dr. Ch. W. Stiles' Article.

Fig. 17.

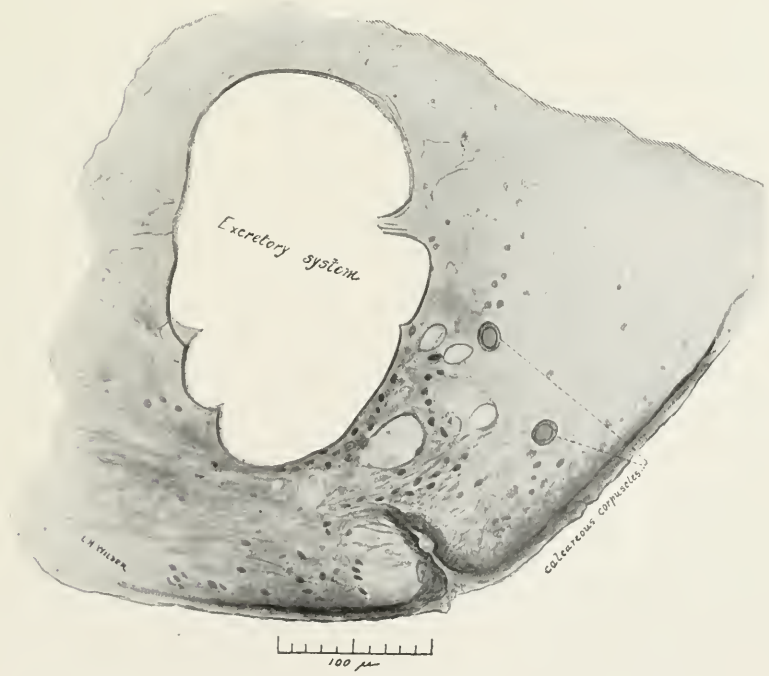

Fig. 18.

CHEILITIS EXFOLIATIVA

By Dr. M. L. Ravitch, Louisville, Ky.

I THINK Dr. H. Radcliffe-Crocker gave the above disease an appropriate name, since the most prominent symptom is exfoliation. Some authors are inclined to recognize it as a form of eczema, as is the case with Besnier and Doyon, who called it "eczema exfoliant des levres," some insist it acts like psoriasis as is the case with Bateman, who calls it psoriasis labialis. Since a few cases were associated with seborrhea, Rayer is inclined to think this disease a part of a seborrheic process and calls it "pityriasis des levres." Drs. Hyde and Montgomery in their text-book insist that the affection should not be confounded with eczema, and call it "Cheilitis Glandularis Aposthematosa." So does Stelwagon and Volkmann. Lately Dr. Hyde recognized this disease as an instance of infective folliculitis.

From all the inquiries I have made I find that so little has been written about cheilitis exfoliativa, that very few of the text-books go into the details of this disease. That quite a good many cases can be found there is no doubt; it is only to be regretted that many general practitioners, not knowing that this is a rare form of disease, overlook it as an insignificant affection, such as chapped lips or fever blisters, for instance. To describe this disease would be a repetition of what little has been written about it; the uncertainties of its etiology and pathology; the failures of the former methods of medical treatment. The symptomatology of the disease is always uniform. The lower lip is usually the one that is affected. The disease always starts with an erythema or œdema, the muciparous glands being subsequently involved. Follicular openings may at times show a scant exudation of muco-purulent secretion with excessive epidermis formation and cornification. In one of my cases the skin of the chin became erythematous. Later on the thick scales become loosened (process of exfoliation), and the lip underneath it becomes dry, glazed, and at times fissured. I never found, as in Duhring's cases, that the disease was associated with a depressed state of the nervous system. In not one of my cases was seborrhea of the scalp associated. Clinically, the disease is closely allied to Paget's disease. Like the latter disease it may start with a sclerotic eczema, later it may assume the form of a dry, scaly or branny encrustation affecting the entire surface of the lower lip, which is darker colored, firmer, less pliant

and elastic than its upper fellow. It apparently has all the phases of Paget's disease, and at times, as in Paget's disease, may become malignant. Perhaps in many a case of epithelioma of the lower lip the initial symptoms were the same as found in cheilitis exfoliativa. In Jamieson's case of cheilitis exfoliativa the thickening of the prickle cell layer was so well marked that Leith thought it to be a mild form of epithelioma. Little, however, is known of its pathology. No pathogenic microbe was ever isolated, though attempts have been made in that direction. Though Dr. Hyde recognizes this disease as an instance of infective folliculitis, Dr. Heidingsfeld was right when he wrote me: "Researches in this direction, as far as I am able to determine, are inclined to show that parasitology is rather accidental than causal in nature." From my own observation I am forced to look upon causal cheilitis exfoliativa as a clinically very important and pathologically most interesting form of keratosis, as found in Paget's disease of the nipple or in other dermatoses where excessive epidermis formation and cornification are the chief features. Whether this process is primarily a hyperplasia of the rete with induced secondary changes or whether it originates as an inflammation of the papillary layer of the corium, producing cell infiltration and vascular dilatation, is only a matter of speculation. Though therapeutic results in former years have not been the most gratifying, the latest reports are very encouraging. Mild antiseptics and X-ray, if they did not accomplish a radical cure, have greatly benefited the disease. Dr. Hyde had best results with very cautious use of X-ray and local antiseptics. Dr. Gilchrist claims that X-ray treatment is the most efficacious. He applies enough to produce reaction. In two private cases he used the X-ray and the result was a cure in both instances. Pure carbolic acid was used by him in one case with great benefit but no cure. In my own cases I used different methods, and the best way to describe them is to give a summary of my cases up to date:

Case 1: W. P., age 39. Was referred to me by Dr. T. Kinnard of Lexington, Ky. Patient was a farmer and stock raiser. Family history good. Denied ever having syphilis. Suffered from leukokeratosis buccalis for over five years. While the case was sent to me for leukokeratosis buccalis only, his lower lip had a typical form of cheilitis exfoliativa. Under 15% solution of nitrate of silver by cataphoresis the lip got entirely well, while the leukokeratosis buccalis persisted, though greatly improved.

Case 2: On March, 1907, I was consulted by H. F., a local dry goods merchant, age 46. Family history good. Never had

any venereal disease. He was an inveterate smoker. For the last two years his lower lip began to feel tight and itchy. At first he thought he had chapped lips, but when he noticed exudation, encrustation and exfoliation, he consulted several physicians, and one of them pronounced it malignant. On examination, I found it to be a usual type of cheilitis exfoliativa. The mucous and salivary glands of the mouth were not affected. After 14 X-ray seances, patient was discharged cured. I saw the patient two weeks ago and not a sign of the disease was noticeable, except that the skin on the lower lip was of darker color than the upper lip.

Case 3: Dr. S. H. R. of Shepherdsville, Ky. Age 35. Was referred to me by Dr. W. Boggess, a very prominent physician of this city. Patient's family history good. Always enjoyed good health. Symptoms identical with case No. 2, except exfoliation more pronounced. Was seen by Dr. Heidingsfeld at the Ohio Valley Medical Society which met in Louisville in 1906. The latter pronounced it lupus erythematosus. The examination was made in the evening and was a hasty one. As the patient could not come to my office regularly I applied a 15% solution of nitrate of silver, followed by Lassar's paste daily. Later on I used X-ray. Patient improved.

Case 4: The patient was referred to me by case No. 2. It is a peculiar thing that patients with a certain disease always know people suffering from the same affection. In this case patient was a whiskey drummer, age 48, with nothing of importance in the medical history, except that he suffered from rheumatism. Patient complained of dryness in the mouth and contraction of the lower lip. The symptoms were the same as in all previous cases, except that the muciparous glands were more involved, the exudation and crusting more pronounced. As patient greatly objected to X-ray exposures, I used Tr. Iodine by cataphoresis and Lassar's paste as a daily application. Patient showed great improvement.

In addition to the foregoing cases, I wish to say that two more cases were reported to me, one by Dr. W. Boggess and one by Dr. F. T. Fort, both of this city.

How long may the relief or cure be expected to last, I cannot say. There is no doubt in my mind that some cases will relapse in spite of energetic and seemingly successful treatment. It might be said that when the true pathology of the disease is established, we may not have to work in the dark, as we do now. For the present all attempts to arrive at the real pathological basis have amounted to naught.

SOCIETY TRANSACTIONS.

BOSTON DERMATOLOGICAL SOCIETY.

January Meeting, 1908.

Dr. Abner Post in the chair.

Tinea trichophytina (Megalosporon Ectothrix). Presented by Dr. C. J. White

The duration of the affection is nine days. The patient is always shaved by a barber. The eruption is entirely limited to the under surface of the chin. Over this region are numerous discrete, round, scaling lesions varying in size from the head of a large pin up to a three-cent piece. Scaling is especially marked on the peripheries of the lesions, while the centers are clearer and covered with fine, furfuraceous scales. A few lesions are small, crusted and situated about the hairs. The lesions are pale red and as a rule are not crusted but covered with scales. According to the history they all appeared at about the same time. Under the microscope spores and mycelium of the megalosporon ectothrix were found.

Discussion:

Emphasis was laid upon the marked resemblance which the lesions bore to impetigo contagiosa of the small type, and upon the fact that so many lesions appeared almost simultaneously, which is very unusual in ring-worm.

Mycosis Fungoides. Presented by Dr. John T. Bowen.

This woman, 56 years of age, has had the disease for ten years, and was shown at a previous meeting of this society. Seven weeks ago she left the ward for cutaneous diseases of the Massachusetts General Hospital with the skin showing very few tumors and with very little generalized infiltration of the skin. Since leaving the hospital she has returned for X-ray treatment but twice. More tumors have developed in the interval, and she states that she has lost fifty pounds in weight. Scattered over the body and to a lesser degree over the extremities are a number of mushroom-like tumors, some of which are two inches in diameter. They are considerably elevated, red in color, with verrucous surfaces. From between the projections exudes considerable secretion. In addition, the eczematous plaques, which at the time of discharge from the hospital were thin and desquamating only slightly, have again become thickened and covered with large lamellate scales. There is also noticeable general glandular enlargement. The patient has recently been readmitted to the hospital and the X-ray treatment which was so successful before has been begun again.

Scleroderma. Presented by Dr JOHN T. BOWEN.

This man, aged 50, is shown because of the condition of his hands, abdomen, chest, and neck. He is an Armenian and in childhood had a disease of the scalp which resulted in a marked thinning of the hair with the formation of atrophic cicatrices; evidently favus. He also had in childhood an ulcerative disease of the right cheek which has left a scar; probably due to aleppo boil. Since coming to this country he has been employed in an establishment where his duties were to wash bottles under a running stream of cold water. Nine months ago he noticed that on removing his hands from the cold water, they felt hot. Soon they began to grow stiff. Motion of the fingers gradually became more difficult, until now not over one-third of the normal motion remains. Three months ago he noticed for the first time that his body, in certain places, was growing stiff. There were no subjective symptoms. The patient had gonorrhœa ten years ago. He admits of the moderate use of alcohol.

The fingers and dorsa of both hands are affected. The skin over the fingers is drawn very tense, limiting motion greatly. The skin is hard, of leathery consistence, and can nowhere be picked up. Its color is cadaverous. To the touch the fingers are cold. Over the backs of the hands the skin has the same cold, hard, tense feel as over the fingers, but is of a more congestive color. Along the borders of the diseased parts the skin is so greatly thickened that it is thrown up into areas of irregular shapes and sizes and with uneven surfaces. Surrounding the umbilicus for a distance of two or three inches and extending upward over the sternum, can be felt a well defined thickening of the skin which is firm, smooth, resistant but not hard, not elevated above the general surface, and which is hyperpigmented over the affected area. Over the sternum near the clavicles and over the back of the neck are a number of areas of oval, round and linear shapes and of small size which are sharply defined, atrophic, and of a dead white color. The general physical examination was negative.

DISCUSSION:

Attention was called to the areas on the neck which are often seen in cases of generalized scleroderma. In this connection a case was recalled whose face was so streaked with ridges as to look as if it were caned. The swollen appearance of the hands was thought unusual and led to the inquiry if the preliminary condition were œdematous.

Tuberculosis Cutis. Presented by Dr. HARVEY P. TOWLE.

This boy, aged 11, presents multiple tubercular lesions of the skin which, judging from the history and from the X-ray plates here shown, are due to primary foci in the bones. The lesions on the hands and fingers began six years ago, and those on the toes five years ago. When the patient was in the cutaneous ward of the Massachusetts General Hospital in 1904, he developed an abscess of the arm which the surgeons believed resulted from a tubercular dactylitis with secondary infection with

pyogenic bacteria. In 1904, owing to extensive necrosis of the second and third right metacarpals, these bones were removed and a sinus leading down to the fifth metacarpal and a necrotic area over the fourth metacarpal were thoroughly curetted at the same time. The wounds from the operation healed completely in three to four weeks.

In September, 1907, the patient returned to the Hospital and was transferred from the Surgical to the Skin Department. He presented at this time much the same appearances as are seen to-day. There were lesions on both hands and feet. On the left index finger and at the base of the left thumb were areas about the size of a twenty-five cent piece, while on the dorsum of the right hand was an elongated lesion with central scarring. On the dorsum of the left foot just above the toes was an area two inches in diameter, while just below the left external malleolus were three lesions varying in size from a twenty-five cent piece to twice that size. On the dorsum of the second toe of the right foot and on the foot itself were other similar lesions. All these lesions were elevated above the general surface, surrounded by a narrow red areola, and except those below the left external malleolus, thickly crusted, with verrucous surfaces. The three lesions on the outside of the left foot were fungoid in character, raised about one-fourth of an inch, with dull red areolæ and rounded edges of a whitish color and with some central crusting. As the boy's father refused to permit any sort of operation, the treatment has necessarily been limited to external applications of which a variety has been tried. Radiographs were taken when the patient was in the ward in 1904, and again in 1907, both of which showed the presence of foci in the bones, but with a marked diminution in size in the later plate.

Two Cases of Syphilis. Presented by Drs. C. J. White and Burns.

Case 1. Miss D., aged thirty, single. In November last a "pimple" appeared on the right cheek. This papule grew and became a "sore" and a week before entrance to the hospital the lesion was poulticed and later incised by a physician. Two days before admission to the skin ward an eruption was noticed on the back, abdomen, legs and face. On January 16, 1908, the patient entered the hospital and showed a universal flat maculo-papular eruption, dull red in color. The original sore on the cheek, which was interpreted as the primary lesion, resembled an open furuncle with considerable surrounding infiltration. The woman received daily injections of one-sixth of a grain of corrosive sublimate. On January 23, salivation appeared and it was noted that the cutaneous outbreak was rapidly fading. On January 31, there was only a faint scar at the seat of the primary lesion, and the roseola was almost invisible. Thus in two weeks by this rather intensive mercurialization practically all outward appearances of the disease had been dissipated.

Case 2. G. Z., aged thirty-six, married. Four months ago the man fell on a sidewalk and bruised his arm. This wound did not heal readily,

but at the end of a month it had resolved itself into a blue-red scar the size of a quarter dollar. Three weeks before entrance to the hospital an eruption was noted, accompanied by headache, malaise and finally sore throat. The man was a knife-sharpener in a hospital and one can't help wondering if the original abrasion could have been infected by one of the hospital knives.

On admission to the ward the remains of the extra-genital chancre (?) consisted of infiltrated blue-red cicatrix, while over the whole body and face appeared a dusky-red, discrete, round or oval maculo-papular eruption. Injections of corrosive sublimate, grs. 1/6, were given daily and three days later the roseola was distinctly less evident. Eleven days after the first injection all cutaneous evidence of the disease was gone and the patient felt well.

These two cases were presented to illustrate the remarkable rapidity with which certain syphilides respond to injections of the soluble salts of mercury. The exhibitors wished to emphasize the fact that in their experience the more dangerous insoluble preparations were never called for in syphilis as it exists in Boston.

A Case of Ringworm of the Beard. Presented by Dr. C. J. White.

The man knew nothing about the cause of his condition which had existed for ten days. When first seen the whole bearded face was a lumpy mass out of which abundant pus could be expressed. The microscope showed ample evidence of the megalosporon ectothrix, both on hairs and in the pus.

Hot fomentations and applications of an ointment containing carbolic acid, naphthol and flowers of sulphur had produced a marked effect in a few days and the exhibitor stated that in his opinion the X-rays were unnecessary in this type of sycosis which usually yielded rapidly to the above method of treatment.

An Unusual Case of Ichthyosis. Presented by Dr. George J. Harding.

Boy, nine years of age. The face, borders of the ears, flexures of the elbows, the axillæ, the popliteal spaces and sacral and genital regions are the principal seats of the disease. On these situations the skin is thickened, scaling, raised above the general surface and more or less pigmented. The scalp is dry and thickly covered by furfuraceous scales. The hair, moderate in amount, is dry and brittle; over the occiput are several dime-sized irregular patches of alopecia. The nails of the fingers and toes generally show dystrophic changes—thickening and brittleness; the matrices of several are inflamed and suppurating. Six months ago the body was almost entirely covered by a scaling eruption similar in character to the present condition, which, under the application of ointments containing boric acid, ichthyol and resorcin, cleared up.

The following history was obtained from the father, a Canadian,

living in western Massachusetts: The boy is a deaf-mute and nearly blind. There is no history of skin disease on the side of either of the parents. There are ten other children in the family, all of whom have healthy skins and no defect of hearing or vision. At birth it was noticed that the child had a somewhat roughened scaling skin. When he was about a year old the skin began to grow more rough, beginning in a few areas and gradually increasing until almost the entire cutaneous surface was covered. At about this time it was also noticed that he was deaf-mute. Defect in vision did not begin until several years later, but it has been steadily increasing, so that he can now see very little. The oculist who examined the eyes reported—"a peculiar and unusual form of keratitis which might be compared to the keratosic condition of the skin." Except for the disease of the skin and special senses the boy has always been healthy and bright mentally.

It may be interesting to note that the boy's mother had been inclined to attribute the trouble to atropine which she took, during pregnancy, for ptyalism.

Discussion:

In view of the seats of predilection, the flexures of the elbows, popliteal spaces and axillæ, the picture of the dematosis did not accurately conform to that of ichthyosis, which shows a preference for the extensor surfaces. Generalized keratosis seemed a name better applicable to the process. The thickened verrucous character of the skin in places suggested ichthyosis hystrix. Whatever the designation to be applied, the condition was evidently a congenital diffuse hyperkeratosis of the skin. The analogy of the disease of the cornea to that of the skin was thought interesting and noteworthy. It was suggested that examination of the ears might reveal still further relation to the cutaneous disease.

F. S. Burns, Secretary.

CHICAGO DERMATOLOGICAL SOCIETY.

Meeting of March 27th, 1908.

Dr. James Nevins Hyde, Chairman.

Case for Diagnosis. Presented by Dr. Anthony.

The patient was a woman 45 years old. She had lived in New Orleans twelve years prior to her removal to Chicago, two years ago. The eruption had been present for six months. It was located exclusively on the face, with a few scattered lesions on the scalp and anterior surface of the chest. The lesions present were nodules symmetrically distributed. They were pea- to hazel-nut size, of a reddish, slightly bluish color, hard and elastic like keloid. They were confluent in the cheeks, producing an uneven nodular infiltration; in the eyebrows, which were thinned, they were so located as to produce a leontiasis.

The patient was in the menopause, suffering from irregular men-

struation, hot flushings of the face, backache and headache. The eruption increased at each menstruation and the lesions became swollen. Involution had occurred in one node of the chest, leaving an atrophic telangiectatic area.

The histopathology of the case was that of scleroderma. Most members of the society regarded it as a case of leprosy. Ormsby emphasized the absence of nasal and mouth lesions and the presence of a few nodules in the scalp. Several thought it was scleroderma or erythema nodosum perstans.

The case will be published later.

Case of Lupus Erythematosus. Presented by Dr. A. N. Mackay.

Mrs. X., age about 45; husband living and in good health; children all living and healthy; no miscarriages; no previous skin trouble. Five years ago the patient sustained a traumatism of the nose, following which present trouble developed on the site of the injury. Six months later she consulted a surgeon, who excised section of diseased tissue and after histological examination, informed her that she had skin cancer, and recommended that she take X-ray treatments. Patient was then given two and three ray treatments each week, at the Presbyterian hospital, for a period of six months. She affirms that her condition grew steadily worse during these treatments, and that prior to this there was no involvement of cheeks, while by the time treatments were discontinued scarring on cheeks existed fully as conspicuous as at present. A patch on neck which developed during these treatments and was treated with rays has not improved, while a similar patch on opposite side healed spontaneously. The case showed well the unsatisfactory side of the X-ray treatment of lupus erythematosus.

Case for Diagnosis. Presented by Dr. Hyde.

The patient was a child 12 years of age, immature, with a good family history who have been under treatment for a year with a disease of the skin, supposed to be of the order of exfoliating dermatitis. The description given by her physician would seem to corroborate such suspicion; the appearance of the patient, however, was against that diagnosis. The upper portion of the body suggested one of the seborrhœic conditions with grayish discoloration of the surface, particularly over the axillary regions, sides of the nose, and elsewhere where there was marked pigmentation. The lower limbs presented the craquelé sometimes seen in xerosis. The elbows and knees were the seat of scaling and infiltrated disks, here and there exhibiting verrucoid filamentous projections as large as a section of a hen's egg. Some of these were infected, secreting a thin seropus. The same condition though less distinct could be recognized on the extensor faces of the joints of the fingers and toes. There had been a history of temperature variations running for the previous month between sub-normal to 102° F. The child had been taking Fowler's solution, eight

drops, three times a day, for a long time previous, and the general impression of those present was that the case was one of arsenical dermatitis.

Case of Tuberculosis Verrucosa Cutis. Presented by Dr. O. S. Ormsby.

The patient was a little girl aged 5 years. Her father died three years ago with tuberculosis. There is nothing else of importance in the family history. The present disorder began two years ago in the site of a burn. The lesion has gradually grown from then until the present time.

When shown there was a dime-sized lesion on the dorsum of the right hand at the base of the third finger. It was moderately elevated, with a warty surface surrounded by a bluish-red halo. There were practically no subjective sensations.

Case of Macular Atrophy of the Skin. Presented by Dr. R. R. Campbell

F. J., aged 43, Russian, married 17 years. Family history negative. At 21 he acquired a chancre; this was treated locally; later he received general treatment. Symptoms of syphilis were absent until three months ago, when an ulcer appeared near the site of the original lesion; this healed quickly under mixed treatment. His wife has had eight children, six of whom are dead; none of these showed any symptoms of syphilis. The present atrophy of the skin began five years ago as variously-sized red macules appearing first upon the thighs; these spots gradually enlarged and new ones have developed from time to time.

Case of Syphilis. Presented by Dr. F. E. Simpson.

The patient, 30 years old, gave no history of infection. Fifteen months ago while under treatment by a physician for a "cold," he had an eruption on the body of supposed medicinal origin. This faded in some weeks, but irregular outbreaks of a similar exanthem have occurred since then, the present one having been out six months. When shown there was an eruption sparsely distributed over the dorsums of the trunk and the extensor surfaces of the limbs, consisting of herpetiform groups of small dark-red papules, many of them excoriated by scratching; itching and other subjective sensations were denied. There were lesions within the mouth and upon the glands; adenopathy was present in the neck, groins, and one epitrochlea; the moustache showed thinning, and there was partial loss of hair on one eyebrow; the nails were very brittle.

The general resemblance of the eruption to dermatitis herpetiformis was commented upon; a ring of small papules on the glans suggested strongly the lesions of lichen planus. By general concensus the exanthem was believed to be a relapsing, accuminate papular syphilide.

A Case of Lupus Tumidis. Presented by Dr. O. S. Ormsby.

The patient was a woman 55 years of age, and had suffered with the disorder for twenty-seven years. The lesion began on the right side of

the upper lip, and gradually spread for nineteen years. One and one-half years ago new nodules began developing on the nose. She states that the lip becomes more or less swollen from day to day. At present the entire upper lip is very much enlarged, more than double its normal size, is brownish-red in color, its surface presenting scaling, and on pressure, typical lupus nodules. It is firm in consistency, showing considerable connective tissue new growth. The nodules on the nose are the ordinary nodules of lupus vulgaris. The family history is negative as to tuberculosis.

NEW YORK ACADEMY OF MEDICINE

Section on Dermatology

Stated Meeting held March 3, 1908

Dr. A. R. Robinson in the Chair

Morphoea. Presented by Dr. Howard Fox.

The patient is 41 years old, married, Swedish. She has had a moderate goitre as long as she can remember. A year and a half ago, while frying some fat, she burned the right side of her face. About a week later the lesions appeared, being confined to the right side of the face. The lesions gradually increased in size and prominence for a month, remained stationary for a year, and have recently become less prominent. Treatment with thyroid extract seemed to produce no improvement.

The case is interesting on account of a traumatism received a week before the eruption appeared and on account of the relationship to goitre. Although the coexistence of scleroderma and changes in the thyroid gland has often been noted. Schubiger has pointed out that in Switzerland, where goitre is very common, scleroderma is very rare.

Pityriasis Maculata Recurrens. Presented by Dr. Wallhauser.

The case which I present for diagnosis came under observation January 2, 1906, or about two years ago, presenting an eruption that has not changed appreciably during this time. It consists of a mixed macular and papular eruption, inclined to superficial scaling. In distribution it is almost general, including the back, abdomen and extremities, with a predilection for the extensor surfaces. A few lesions have appeared in the palms of the hands. The face and scalp are not involved. The mixed character of the eruption is due to the age of the individual lesions. Several small purplish macular, slightly elevated oval or rounded lesions would appear on various parts of the body and progress to form macules or papules, in size varying from a lentil to a large bean, which remained stationary for several weeks and then gradually developed slight scaling, after which they retrogressed leaving superficial

scarlike lesions. The color changed with the stage of development of the lesion from a light to a dark purplish red, which gradually faded. The evolution of the lesion is very slow and may be put at from six months to a year, varying with the degree of development to the papulo-scaly type.

My first diagnosis was pityriasis rosea, with a question mark, on account of the strong resemblance to the maculo-papular eruption of syphilis. After observing the eruption for about three weeks, without its advancing as in pityriasis rosea, notwithstanding the fact that the patient denied all possibility of an infection, and which I had no reason to doubt, he was put on a specific treatment, which was continued for two months without any appreciable change in the eruption being noticed. On account of the slight scaling, which was becoming more evident, a diagnosis of psoriasis was thought of and the various antiseptics, including the treatment by chrysarobin, were applied without any effect. As the patient was becoming discouraged regarding the persistence of his condition, he was referred to Dr. H. G. Fox, who kindly returned him, with a letter in which he admits the resemblance to syphilis, and added that he would have made a diagnosis of syphilis without a history of the case. His diagnosis was pityriasis maculata recurrens, a form of pityriasis undescribed, of which he had had one other case. On Dr. Fox's advice the patient was put on a restricted diet. This was continued until the patient had lost considerable weight and otherwise showed the effects of depletion—as bodily fatigue, etc. His diet was them increased and a lotion of resorcin advised locally—and a combination of magnesium sulphate and magnesium carbonate was given to correct an existing constipation. Since beginning this plan of treatment a slight improvement is noticeable in that the eruption is less and the scaling papules seem to involute to the macular stage more rapidly.

In looking up the literature for a classification of this condition, we find a variety of cases of pityriasis of a persistent nature, consisting of various clinical manifestations, resembling according to different observers, many of the well established clinical entities of an erythematous, macular, papular or scaly type—as pityriasis rosea, lichen, psoriasis, eczema seborrhoeicum, etc. The resemblance to these various conditions has given rise to names synonymous with the condition of resemblance, with an added qualifying prefix, as the parapsoriasis of Brocq, parakeratosis of Unna and Pollitzer, lichenoid eruption of Neisser, erythrodermie pityriasique en plaques disseminées of Brocq, etc. On account of the variety of clinical description a classification has been attempted. That of Brocq has been quite generally accepted on account of convenience from a clinical standpoint of division into classes according to the morphology. His division, briefly, consists of three classes, as follows:

1. Parapsoriasis guttata, in which the eruption resembles an early psoriasis.

2. Parapsoriasis lichenoides, in which the elementary lesions consist of flattened papules developing retiform patches by coalescence.

3. Cases occurring as sharply defined coin-sized patches of pityriasis, resembling the erythematous stage of mycosis fungoides, or eczema seborrhoicum. Under this head he includes his erythrodermie pityriasique en plaques disseminées.

If we accept this classification we can place the case under discussion in class one, or parapsoriasis guttata. But the difference in clinical course in the cases classified is so different that it is more than likely that several distinct diseases have been included. There is certainly no resemblance in this case to the one shown by Dr. Trimble, October 29, 1907, which was accepted as a case of Brocq's pityriasis in patches, except the persistent character of the eruption, which may be considered as recurring in this case rather than persistent.

In a previous case resembling the erythematous stage of mycosis fungoides the eruption was well developed when the patient came under observation and in consequence an opportunity of observing its development was not afforded, yet it did not change in several months by the development of new lesions at intervals of a few days as in this case.

I am, therefore, inclined to accept the diagnosis of Dr. Fox—of pityriasis maculata recurrens, as this name best describes the condition in question and should be maintained as a clinical entity until a closer relationship can be established between the various forms of persistent pityriasis than a resemblance pathologically.

DISCUSSION:

Dr. Trimble said that he considered this to be a case of parapsoriasis of Brocq. It was, in his opinion, identical with a case he had shown before the section, with perhaps a difference in degree. He considered his case to belong to the third variety of parapsoriasis, that is, erythrodermie pityriasique en plaques disseminées, and he thought probably the case under discussion might be assigned to the first variety, that is, parapsoriais guttata.

Dr. Lapowski said that he considered this to be a typical case of psoriasis, with a seborrhoeal element added. He objected to the term "parapsoriasis" because it was impossible, from Brocq's description, to form a clear idea of what he meant by it.

Syphilis of the Breast (same as Case 1, Feb. 4, 1908). Presented by Dr. Lapowski.

Some gentlemen in discussing this case last month expressed a doubt as to the diagnosis of Paget's Disease, suggesting instead of gummata syphilitica. I have given the patient antisyphilitic treatment for the past month, and the result bears out the correctness of the views of these gentlemen. The patient received one injection of calomel and one of salicylate of mercury, inunctions of 20.0 g. Ung. Hydrarg. Dil. U. S. P., and 60 g. of Potassium iodide. The deep ulcerations to the left of the nipple are nearly levelled, the flat, round superficial ulcer is quite well. I forced the treatment, in order to be able to present the case at this meeting.

Large Gumma of the Breast. Presented by Dr. Lapowski.

The patient is a woman aged 56 years, married 40 years. Her present history is negative. Four out of twelve children died at various ages between 2 and 8 years, of "summer complaint" and diphtheria. The oldest child is 34 years old and the youngest is 16 years old.

Six out of the eight living children suffer with nail diseases, and one of the sons has chronic aphthous ulceration of the mucous membrane of the mouth in connection with his nail trouble.

Four years ago the patient came to the Good Samaritan Dispensary with swollen, hard, movable, smooth, painless glands in both occipital, both auricular, the submaxillary, both axillary (especially the left), left clavicular, and left cubital regions.

In each breast, especially in the left, a hard, movable, painless, sharply defined mass was felt, starting from the nipple, reaching up to the upper third of the breast. The mass was smooth, the skin movable, of normal color, or near the nipples adherent to the mass and slightly red. The glands and breasts had begun to swell several months previously while she was on the sea, and she suffered from chills and fever at the same time. The nail of left index finger was changed in color. It was dark, spotted at the distal end, the surface smooth, and not brittle. There were no other manifestations on the skin or mucous membranes, or in the internal organs. The urine was normal. The patient looked well, and did not complain of any pains. No blood examination was made. The patient was advised in other hospitals to have her breasts removed.

Under antisyphilitic treatment consisting of two calomel injections and potassium iodide all the glands disappeared in 5 weeks, and the hard masses in the breast greatly diminished, leaving only slight hardness near the nipples.

The patient was discharged.

After being well for three years she returned 3 weeks ago in the following condition:

Right breast a hard, painless, sharply defined, movable smooth mass of the size of a large orange, starting from the nipple and reaching up to the upper end of the breast can be felt under the skin. Alongside the nipple, and running upward, the skin is adherent to the mass, having a vivid red, angry color, disappearing under pressure, but quickly reappearing. The rest of the skin is normal in color and movable. There are no glands in the right axilla.

Left breast: A smaller hard mass of the same character, but covered with normal skin which is not adherent. There are no glands in the left axilla. Other glands are not perceptible. Ther are no other manifestations.

On account of my former experience with the patient I have to accept her case as of syphilitic nature—and present her as such.

DISCUSSION:

Dr. POLLITZER said that he believed this to be a carcinoma and not a gumma, basing his diagnosis chiefly on the appearance of the skin at one point where the epidermis was broken through by growth from below, Under similar conditions a gumma would have broken down and left an ulcer. He advised three or four weeks of antisyphilitic treatment, and then, unless great improvement had taken place, amputation.

Dr. CLARK said that he agreed with the diagnosis, and excluded carcinoma on account of the slight glandular involvement, the lack of ulceration, and the non-attachment to the chest, being of so long duration and so large. He advised biopsy to establish the diagnosis.

Dr. KLOTZ said that he believed this to be a gumma on account of its consistency, and the previous ocurrence as well as absence of enlarged glands and of pain. He would give mercury energetically, but not rely on potassium iodide.

Dr. ROBINSON believed that the hardness, irregularity of contour, the infiltration into the cutaneous tissue in the direction of the nipple and the peculiar color and drawing in of the surface towards the growths beneath, pointed to carinoma as more probable than gumma. The absence of enlarged axillary glands was not against carcinoma. He would advise large doses of iodide of potassium before advising an operation, as the diagnosis of gumma by Dr. Lapowski may be correct.

Dr. LAPOWSKI, closing the discussion, said that he did not consider the appearance of the skin over the tumor at all characteristic of carcinoma, and that with the previous historry of a similar condition in the breasts which had disappeared under active mercurial treatment, he cnsidered this mass was decidedly syphilitic.

Lupus Disseminatis. Presented by DR. LAPOWSKI.

The patient is a woman 30 years old, married, with two healthy children. There is no family history of tuberculosis and no history of syphilis.

Five years ago she came to the Good Samaritan Dispensary with patches of papulo-tubercular lesions on the left knee, the right arm, the trunk below the scapula and on the chin. In the sputum at that time tubercle bacilli were found. Various local measures—plasters, high frequency electricity and X-ray were tried without any effect—the lesions would flatten but never disappear. After a short time they would attain their usual size: that of a pea. The best results, comparatively, were obtained from calomel injections—but even under that treatment, the lesions did not disappear. All treatment was stopped and the patient was advised to take the best possible care of her general health. The lesions on the back are less prominent, but on the chin, arm, and knee, remain stationary for the last two years.

Tuberculide. Presented by DR. CLARK.

The patient is a woman 20 years old, Irish, single. There has never been any tuberculosis in her family; they have been healthy, strong people. She has always been well, never had any illness except typhoid seven years ago. Occasionally she has had colds which were easily thrown off.

When getting well from typhoid, she noticed little pimples behind

the ears which would grow slowly, break and leave scars. A little later she noticed a few on the extensor surfaces of the forearms and below the knees. These pimples would slowly disappear, leaving little white spots, and others would come out and go through the same course. These pimples kept coming and going until the patient came to this country two years later, and almost entirely disappeared for one year except for an occasional one behind the ear. Four years ago the pimples began to come again on the arms and legs and she has had them off and on ever since—better and worse at times and tending to come in small crops. They necrose at the center and leave a punched out scar behind. These lesions the patient now shows in all their typical stages on the arms and legs. On the forehead she has three marble sized masses, quite hard and a little tender, movable in the deeper parts, and situated beneath the skin, though the skin is a little inflamed over one swelling. These lumps are of two weeks' duration and are now quite rapidly disappearing with the treatment. She had similar masses on her forehead one year ago, lasting two months. Behind the ears the skin seems shiny and stretched, and scattered in this are several small inflamed papules, a few of which are necrosed at the center, and several faint white scars. The patient shows a very decided response to the ophthalmo-tuberculin test—2 drops of a half per cent solution having been instilled in the eye 24 hours ago.

Case for Diagnosis. Presented by Dr. Janeway for Dr. Bulkley.

The patient is a man 33 years old. He has always previously been in good health. He has never had any trauma or operative procedure. His occupation is that of a turner, and he thus stands all day at a lathe. Twelve years ago he had gonorrhœa. He denies syphilis His present trouble began three years ago, with an attack similar to the present, in the left leg, so that the following description of the present trouble will represent all former conditions. In all, during the past three years, he has had five such attacks, sometimes in one leg and sometimes in the other; once in both legs together. Their usual duration is four months. The present trouble began two months ago, and has gradually increased till the present condition has resulted. He now has upon the anterior and internal surface of the left leg below the knee a doughy, slightly swollen, and congested red area about six inches long and three inches wide, which pits distinctly on pressure. It is not tender, and the only abnormal sensation is itching. There is no pain in walking. The temperature is not elevated.

DISCUSSION:

Dr. Robinson had seen similar cases of deep inflammation which frequently recurred. He regarded the case as one of deep infection, the result of an exogenous toxæmia, the endothelial cells of the part being vulnerable to the toxine.

Dr. Pollitzer said that the condition was very suggestive of erythema induratum and he would like to know the result of a tuberculin test.

For Diagnosis: Tuberculide or Syphilis? Presented by Dr. Lapowski.

The patient is a man twenty-five years old, married three years ago. No children. His family history is normal. When four years old the patient was vaccinated, the sore running a normal course. When eight years old a white speck, surrounded by a red border, appeared on the left eyeball. It was treated by Dr. Claiborne in the Vanderbilt Clinic, where the diagnosis was keratitis marginata—as seen from the dispensary card—which the patient had kept and brought to me. He was given a yellow ointment locally and eye drops, but no internal medicine. Two weeks later "running sores" appeared over the whole body lasting several months. The patient went to Mount Sinai Hospital Dispensary, where the eruption was seen by Drs. Lustgarten and George Fox. The patient could not tell what diagnosis was made at that time, but the eruption must have been a very peculiar one, as he was directed to go to the office of one of the physicians to be photographed. He did not go. Privately he was treated with mercurial inunction and potassium iodide. The eruption disappeared, leaving scars visible as present on the sacral regions. The eruption reappeared every winter for the next seven years, especially attacking the lower extremities, leaving very marked dark brownish scars, which persist. Under mercury and potassium iodide the eruption usually disappears. When fifteen years old, there was a relapse on the left eye consisting of a white speck, surrounded by a red border. He was treated in the Vanderbilt Clinic by Dr. Holden, with mercurial inunctions and potassium iodide, and drops locally. After four weeks' treatment he was cured. Several weeks later, ulcerations appeared on both legs. He came to the out-door Department of the Skin and Cancer Hospital, where I saw him for the first time, ten years ago. I distinctly remember that neither Dr. Bulkley, who saw the patient, nor myself, could accept the lesions on the legs as syphilitic and the patient received one-fourth grain tablets of calcium sulphide, which he took to the amount of about 100 grains.

The eruptions on the legs disappeared, leaving scars, and since then the patient has not had any lesions on the lower extremities—which, by the way, goes to prove—that we cannot always judge ex juvantibus. When nineteen years old he had a superficial lesion on the glans penis lasting a month and a half and disappearing under local treatment.

When twenty-three years old he had an ulceration on the glans penis which disappeared under antisyphilitic treatment, leaving very deep disfiguring scars, which traverse the glans in various directions. Two months ago the left eye began to trouble him. Dr. Tynson (Vanderbilt Clinic) gave him mixed treatment. Several days ago he came to the Good Samaritan Dispensary and the following condition was found. He was well nourished, healthy looking. His face and whole body, especially the sacral and gluteal regions, were covered with scattered, deep, white pitted scars. There was no pigmentation around any of the scars above the

knees. Only the lower two thirds of the legs were covered with dark brownish, deep, smooth, cigarette-paper like scars, not so markedly pitted. The edges of the scars are darker than the centres. The palms, soles, nails, and mucous membranes are normal. No glands enlarged.

Left eye (examined by Dr. Percy Freidenburg): Complete abducens paralysis, and keratitis interstitialis.

DISCUSSION.

Dr. KLOTZ said that the scars on the legs were not sufficiently characteristic to make a diagnosis. On the glans penis, on account of the peculiar character of the tissue, any deep lesion might leave such scars.

Dr. LAPOWSKI, closing the discussion, said that the symptoms in the eye were characteristic of syphilis, while the lesions on the trunk and the extremities would be considered characteristic of a tuberculide, by anyone ignorant of their history. He would report later the result of intense treatment.

Intermittent Limping (Claudication Intermittent, Charcot). Presented by Dr. LAPOWSKI.

The patient is a man forty-six years of age, married, a Russian of Jewish descent. Denies syphilis. Has had three attacks of gonorrhœa, the first when twenty years old, the last five years ago. There were no gonorrhœal complications. He does not drink, but smokes heavily—thirty cigarettes daily. The present affection commenced gradually about two years ago, with pain in the foot on walking. He complained of cramp-like pains and pressure in the calf of the right leg, which always attacks him after he has walked two or three minutes and obliges him to rest a few minutes before going on. No pulsation can be felt in the right dorsalis pedis artery nor in the tibialis postica, though both these arteries can be felt beating in the left limb. The pulsation of the femoral artery is normal in both groins. Both dorsal and solar surfaces of the right foot from above the malleolus down to the tips of the toes are changed in color. The outer and inner edges are pale, the distal ends of toes are of death-pale color, the toes and surrounding surface cyanotic and the rest of the dorsal aspect congested, the redness disappearing under pressure, but not entirely, firm, hard hæmorrhagic scars being left. On the red surface of the dorsum, whitish islets are scattered. When the patient is examined in a horizontal position, the redness near the toes disappears, becoming paler. If examined right after walking, a paleness can be noticed in the spots which are congested during rest. There is no anæsthesia. There is no evidence of any disease elsewhere in the body. The radial arteries feel normal. The pulse is about 90, of moderate volume and of fair pressure. The knee and plantar reflexes on both sides are normal. The pupils are equal and react normally to light.

Urine: Spec. gr. 1022. $^1/_{20}$% of albumen, many mucous and hyaline casts, and some squamous epithelia.

The patient at present suffers from two distinct kinds of pain: (1).

The cramp-like muscular pains of intermittent claudication (angina cruris) as already mentioned, and (2), a local pain in the toes, which has sometimes kept him awake at night, but now under treatment has disappeared. He has flat feet.

The case is a typical one of obliterative arteritis, which often leads to gangrene of the extremities and occurs in men in the prime of life, especially in Jews from Poland, and Russians, who have been accustomed to smoke cigarettes rather freely.

The cases reported in literature are nearly 90% of Polish and Russian Jews. Syphilis apparently plays no part in the etiology. The really essential cause of the arterial disease in these cases, however, remains unknown.

The interest of the present case lies chiefly in the remarkable intermittent spastic contraction of the minute cutaneous blood vessels of the foot which precedes the muscular cramp-like pains. The congested condition of the foot in the present case may be explained as an automatic attempt to compensate for the arterial obstruction by dilatation of capillaries and veinules—that is an automatic attempt to favor collateral circulation, and as long as collateral circulation is present amputation is to be postponed. Moszkowicz's method was tried on our patient to determine the condition of collateral circulation. For the healthy limb the circulation returned in a few minutes, but in the affected foot it took about twenty minutes before the redness returned, proving that the deep arterial vessels are still open for the circulating blood and sustain in a small degree the life of the tissue elements.

DISCUSSION.

Dr. KLOTZ said that Durandard in a Paris thesis of 1902, from the clinic of Dieulafoy, represents intermittent limping as a symptom of a specific obliterating endarteritis of the large arteries of the extremities, leading to interference with the circulation, particularly under the influence of muscular action during an attempt to walk, and that energetic antisyphilitic treatment should lead to improvement. Dieulafoy insists on injections of the biniodide of mercury. If the symptoms were due to spasm of the muscular coats of the arteries, why should this spasm occur in one leg and not in the other, and only when that member is set in motion?

Dr. DANA HUBBARD said that he had seen a similar case in a delicate country-bred girl whose diet was largely cereal. She had intermittent attacks of coldness and numbness of the feet, generally thought to be due to an obscure hereditary syphilis. She improved greatly on a change of diet, omitting all cereals, but relapsed when cereals were added again. She was finally cured by proper regulation of the diet. It seemed quite possible that her symptoms had been due to the toxic action of some poison contained in the cereals, produced by a fungus occurring in the grain, and akin to the ergot of rye.

Dr. LAPOWSKI, closing the discussion, said that the fact that the affection was unilateral did not prove that it was syphilitic, because there was no reason why other poisons besides the syphilitic might not confine their action to one foot. While a syphilitic obliterating endarteritis produces a somewhat similar clinical picture, yet in this case the intermittent spasm of the arterioles is the char-

acteristic feature. He was avoiding all local irritation very carefully and was relying upon local galvanic baths and large doses of potassium iodide and antipyrine in the treatment.

Psoriasis of the Palms and Soles. Presented by Dr. ROBINSON.

The patient is a man fifty-four years of age, occupation, bricklayer. He gives no history of syphilis. He has had psoriasis since twenty-five years of age, and I have had him under my observation more than ten years, having treated him for several attacks of the disease. He states that the eruption has always appeared upon the palms and soles, when it appeared upon the body in general. The present eruption does not differ in character from previous attacks as I have seen them. He has a well-marked psoriasis of all parts of the body, scalp, face, chest, body and extremities. Both palms and soles are covered with lesions, so that in some places it looks like a general keratosis of the part. On the fingers the lesions are more isolated, and vary in size from a large pin head to a pea, sharply limited, with a tendency to clearing in the center, much as in syphilis. The nails are also affected.

The case is shown on account of the comparative rarity of psoriasis of the palms and soles, and the fact that these parts have been in this case so frequently involved in the general eruption.

Psoriasis in a Syphilitic Subject, with the Lesions Much Resembling a Syphilide. Presented by Dr. ROBINSON.

The patient is a man twenty-eight years of age, occupation, undertaker. His general condition is not vigorous. He had a chancre five years ago, seated near the root of the penis. He was treated by me at the time and since, with mercurials and very little iodides. He never had many cutaneous lesions, but sores in the buccal cavity were frequent and obstinate to treatment. The present eruption commenced two months ago and consists of several hundreds of lesions, small to large pea-sized, situated especially upon the posterior surface of the trunk, although they are also plentiful upon the arms, legs, front of the trunk and upon the scalp. The palms are free, also the buccal cavity. The lesions are decidedly grouped and they show no signs of increase in size by growth at the periphery as usually occurs in psoriasis vulgaris. A single lesion is sharply limited, elevated, light red with a tinge of yellow and more or less scaly on the surface. On the forearms the scales are of the classical white appearance. On account of the grouping, the great uniformity of size, the color and the slight scaling in many of them the diagnosis between psoriasis and syphilis was a question, and I believe the previous syphilis gave a type to the eruptions in this case. This was the first attack of psoriasis.

DISCUSSION.

Dr. LAPOWSKI said that he had seen a similar case with an apparently typical psoriasis of the skin, in a patient with a history of syphilis who had also typical

mucous patches in the mouth and at the anus. In all such cases where the diagnosis is doubtful he advised intramuscular injections of calomel, and no other treatment, not even bathing. In a week or ten days the syphilitic lesions will undergo a very remarkable change while the psoriatic efflorescence will show the white scales more prominently than before the administration of calomel.

THE PHILADELPHIA DERMATOLOGICAL SOCIETY.

The regular monthly meeting of the Philadelphia Dermatological Society was held at the Polyclinic Hospital, on Tuesday evening, April 21, 1908, at 8:30 o'clock. Dr. M. B. Hartzell, presiding.

Dr. Hartzell showed an excellent photograph, taken by the Lumiere method, of a case of Raynaud's disease. The picture presented an exact reproduction of the dilated blood-vessels of the left foot, the bluish-red appearance of the skin, and the yellowish-brown pigmentation of the toe-nails.

Bromide Eruption in an Infant, An Extensive Case of. Presented by Dr. Quinlivan.

The case exhibited was an infant, seven months of age, fat, and excepting the skin lesions, healthy in appearance. The first outbreak occurred four months ago, at which time a few "pimples" appeared upon the face; these increased in number, and became almost generalized. At the present large confluent patches are seen on the face, scalp, ankles, legs, forearms, wrists, upper arms, buttocks, and a few on the trunk. The lesions on the face and scalp are palm in size, elevated, reddish-yellow in color, with a papillomatous, "cauliflower-like," surface. Those on the wrists and ankles are silver-dollar in size, raised from one-eighth to one-quarter of an inch, sharply marginate, with a flat surface, on which is seen numerous miliary abscess openings. The large papillomatous lesions are made up of grouped pustules, from which can be squeezed a cheesy material. Two weeks before the eruption appeared the baby was given strontium bromide; this drug was only administered for two weeks. The marked resemblance of some of the lesions to those found in blastomycosis, and in mycosis fungoides was remarked.

Chromidrosis, A Case of. Exhibited by Dr. Davis.

The patient was a male twenty-one years of age and born in France. Two years ago upon removing his undershirt, he noticed a faint discoloration on that portion, in contact with the axillæ. He had for years perspired considerably, but until that time he had never noticed any color to the sweat. The sweating has progressively increased, until now even in cold weather the shirt in contact with the axillæ is wet after a few minutes

wear. On examining the undershirt the part that had been in contact with the axillæ was found to be stained a deep brownish-red. The other parts of the body are not affected by this anomaly. The hairs in the axillæ apparently do not contain the small nodes which are frequently found in this condition. Dr. Hartzell mentioned various cases of this disorder that he had seen, and referred to one, in which the "red-sweat" was exuded in the perineal region. The patient also showed marked dermographism, but no "wheals."

Pigmented Naevi, A Probable Case of Multiple. Presented by Dr. Schamberg.

A well-formed girl twelve years of age was exhibited, with thirty or forty lesions on the trunk, which had lasted since birth. The chest, abdomen, upper arms, but chiefly the back, were involved. The lesions were sharply marginate, wart-like in appearance, but superficial and smooth on pressure, reddish-brown in color, and from split-pea to dime in size. The follicles of the skin could be plainly seen in these patches, giving a stipled appearance. There were no hairs in any of the lesions. The girl was also recovering from a recent herpes zoster, on the left side of the neck and shoulder.

Epithelioma of Face. Presented by Dr. Pfahler.

The patient was a woman fifty-two years of age. The present lesion started as a small ulceration, upon the right side of the forehead, five years ago. This lesion increased in size, until at present there is a silver-dollar-sized lesion adjoining the right eye, which is very superficial, with a raised, serpiginous border, and practically no ulceration. This patient had received fifteen X-ray exposures during the last five months, with some improvement. The resistance of superficial epithelioma to treatment was discussed.

Xeroderma Pigmentosum, A Case of. Presented by Dr. Stout.

The patient was a well-built boy of two and one-half years. The parents noticed nothing unusual about the boy, until at the age of one year numerous freckles appeared upon the face. These freckle-like lesions have continued to appear on the face and also on the scalp. The boy seems to be irritable and to have some photophobia. At the present time there are hundreds of lentiginous lesions on the face and scalp. The cheeks and nose showing the greatest number. The lesions are from light-brown to jet-black in color, mostly round, but some are irregular in shape, practically all are smooth, and from small pin-head to split-pea in size. Small telangiectases are found on the cheeks, between, and in close prox-

imity to the pigmented lesions. The scalp in addition to the freckle-like lesions is somewhat scaly and rough. The skin of the face is also rough and scaly. Pigmented areas are also found on the mucous membranes of the lips. On the forehead two irregularly-shaped, jet-black pigmented lesions are found, resembling markedly the early stage of a melanotic sarcoma. The trunk is free, the face and the scalp being the only areas involved. There are two other children in the family who, according to the father, have skin without freckles. The interesting fact was however discovered, that probably another child in this family had the same disease. The father stated distinctly that this other child had a large number of "freckles" on the face. This latter child died from an undiscovered cause. The father has had psoriasis for some years. This case was presented through the courtesy of Dr. Stelwagon.

Pigmented Naevus Treated by Freezing. Exhibited by Dr. SCHAMBERG.

The patient treated was a male, twenty years of age. The lesion consisted originally of a small-fist sized lesion, brownish in color, sharply marginate, and covered with hairs. The site of the nævus was the left side of the forehead, between the eye and the hairy border. The patch was frozen with carbon dioxide, light pressure being used for nine seconds. A razor-bag was first held over the cylinder attachment, and compressed until it became solid, this frozen stick was then cut and applied to the nævus. Much improvement has resulted from the one application; the pigment being lessened and the hairs removed.

Lichen Planus, A Case of. Exhibited by Dr. STOUT.

The patient was a negress thirty-eight years of age. Five months ago she first noticed the appearance of "bumps" on the wrists. These lesions have increased in size and number; until at present there are about fifty, large pin-head-sized, flat, shiny, blackish, umbilicated, slightly scaly, irregularly shaped papules. These lesions are on the flexure and extensor surfaces of the wrists and hands, and also on the ankles. The mucous membranes of the mouth are not attacked. There is intense pruritis. The interesting fact was discussed as to the resemblance and difference between lichen planus in the negro and the white races. It was also mentioned, how prone it is for almost any inflammatory disease of the skin to produce increased pigmentation in the negro.

Sarcoma Treated by the Roentgen Rays, A Case of. Presented by Dr. PFAHLER.

The patient was a male thirty-six years of age and apparently in the best of health. Some months ago the left testicle was removed because of a tumor. This growth upon microscopic examination proved to be a

round-celled sarcoma. Some six months ago the patient developed a hydrocele, which was operated upon. The wound from this incision persisted in remaining open, and two nodules were palpated in the left groin. Five months ago exposures to the X-rays was started. The patient was exhibited to show how nicely the wound has now healed. The nodules have also disappeared in the groin under this method of treatment. The interesting fact is noted that the pubic hairs on the left side have disappeared, because of exposure to the Roentgen rays.

Epithelioma, A Probable Case of. Exhibited by Dr. PFAHLER.

The patient was a male, fifty-one years old. It had been rather hard to arrive at a diagnosis in this case, as the patient originally had presented himself after treatment by "quacks." The original condition consisted apparently of two ulcerated lesions on the left side of the neck. The condition, however, has been very much improved by X-ray therapy. The patient is tuberculous, the tubercle bacilli having been found in the sputum. There are also tubercular ulcerations of the larynx.

Dr. Pfahler also presented a microscopic slide, that showed a papillomatous growth, from the finger of a roentgenologist, that had been caused by the frequent use of the X-rays.

Dr. Schamberg exhibited a case with the diagnosis of ACNITIS. The patient was a male of twenty-nine years, and had had the condition for nine weeks. The lesions, with the exception of two on the penis, were localized to the face. This case is to be reported in detail at a later date.

A Case for Diagnosis. Presented by Dr. DAVIS.

The patient a male of thirty years, had originally been seen by Dr. Davis, in Dr. Harte's surgical ward at the Pennsylvania Hospital. Unfortunately very little history could be obtained as the man was a Greek, and could not talk English. The patient was admitted to the hospital five weeks ago, with a fist-sized bubo in the right axillæ, this swelling was hard and inflammatory. Under the nail of the middle finger of the right hand, was found a slightly inflammatory, papillomatous growth. On this same arm and hand, at various intervals, were found about a dozen pea to walnut-sized tumors, of the "cold abscess" type. These tumors were compressible, reddish-brown in color, elevated, circumscribed, not painful on palpation, and gave the sensation of being "hollow." The lymphatic cords could be felt, the thickness of thick twine, extending from the elbow to the axilla. These tumors seemed to be connected with the lymphatic system, as they were in direct contact with the thickened lymphatic cord. Cultures and smears were made from the fluid from the growths, but with the exception of a few staphylococci the findings were negative. Tubercle bacilli and blastomyces were absent. There has been no eruption on the body or adenopthies. Dr. Schamberg suggested the possibility of blastomycosis with subcutaneous abscess formation. Unfor-

tunately the diagnosis remains somewhat in doubt. It should be mentioned that there was only a slight elevation of temperature, thus apparently excluding bubonic plague.

Dr. Schamberg showed two specimens of pediculi, the one equine, and the other bovine. The pediculus obtained from the cow resembled markedly the species that attacks man. The interesting fact was developed that the woman who owned the cow from which the pediculus was obtained, suffered from intense pruritis at night. Those present discussed the possibility of the pediculi from the cow, being the source of the nocturnal pruritis of the woman. The pediculus obtained from the horse was of an entirely different type, the head being long, and turtle-like.

Frank Crozer Knowles, M. D., *Reporter.*

REVIEW
of
DERMATOLOGY AND SYPHILIS

Under the charge of A. D. Mewborn, M. D.

BULLOUS DISEASES.

By John T. Bowen, M. D., Boston.

Epidermolysis Bullosa Hereditaria, and Its Relation to Raynaud's Disease. Linser. (*Archiv. für Derm. und Syph.*, lxxxiv, p. 369.)

Linser records several observations which point to a connection between epidermolysis bullosa hereditaria and vaso-motor neuroses, especially Raynaud's disease.

1. The Maier Family. In this family a three-months old child had been affected with typical epidermolysis bullosa since its birth; and in the same village there were two sisters who were similarly affected, remote cousins of the infant. The mother of the two sisters, who was a woman of seventy-four, complained of stiffness in the fingers and severe pain whenever she put her hands in water. The father of the infant had a certain form of ichthyosis, and was quite susceptible to the cold. A brother of the infant had been affected in the same way and died when six months old. The bullæ were produced by the slightest pressure or rubbing, and attained in a short time quite a large size. A very considerable hyperidrosis was noticed in the child. Examination of the blood showed a considerable lymphocytosis.

The two sisters, who were respectively forty-four and twenty-nine years old, had also been affected with a typical case of this disease since their birth. In the case of one sister, in certain instances scars were left after the lesions. During the menstrual period, the tendency to the formation of bullæ was diminished. The patient had a rheumatic polyorthritis, and during this time the bullæ did not appear. With regard to the second sister, it was similarly noted that when she was affected with an inflammation of the lungs, the bullæ ceased to appear. This patient suffered from attacks of headache, and pain and numbness in the fingers, and was troubled with hyperidrosis. There was also a diminution in the bullous formation during the menses.

2. Family Sch. These were two boys, brothers, aged respectively fourteen and twelve, in whose family there was a great sensitiveness to cold. Two older brothers died of the same disease when six and eight years of age. The skin of the two boys presented a remarkable reddish-blue color in even moderately cold weather; and before the appearance of bullæ the fingers were often dark blue and very painful. Three years previously the younger of the two had lost half of the forefinger of the right hand, without having been specially injured.

There was a complete absence of nails of both hands and feet. The skin of the fingers and backs of the hands was atrophic, thin, and bluish-red in color, especially in the case of the younger child. There were pigment spots and small superficial scars of the lower arms, especially about the elbows; and there was atrophy, also, of the back of the feet. It is to be remarked that in the case of these two brothers, the cause of the formation of bullæ consisted not solely in mechanical influences, but especially in those of temperature.

From histological examinations, the writer thinks it probable that in the formation of bullæ there is a damage of a particular part of the epithelium, perhaps a necrosis of a small area of cells, which has an inflammatory action on the adjacent parts, and this causes exudation and the formation of bullæ. The position of the bulla is in the lowest layer of the rete Malpighii. This necrosis of the epithelium, he considers, in these cases, is produced by a vaso-motor neurosis. This, he thinks, is proved by the reddish and white appearance of the fingers in the presence of very slight changes in temperature; by the fact that in one case the mother had Raynaud's disease; that the finger of one of the patients had been lost by gangrene; by the diminution in the bullæ formation during the menstrual period in two of the patients and its complete cessation during acute infection, and by the headaches and hyperidrosis. To these reasons may be added the falling out of the nails in two cases, and the atrophy and scarring. The fact that in two of the cases no hereditary element could be detected does not, in the writer's opinion, warrant the separation of the cases into two affections.

Polymorphous Dermatitis and Pemphigus Vegetans. CONSTANTIN. (*Ann. de Derm. et Syph.* November, 1907.)

Pemphigus vegetans, as described by Neumann in 1886, is an affection characterized by an eruption of bullæ leaving vegetating surfaces, with a quite constant localization and a fatal course. To this serious typical form a less common benign form has been added which presents, in the end, about the same features.

As to the nature of pemphigus vegetans, and its exact place in classification, opinions are divided. Brocq declares that there are two opinions, one of which asserts that it is a simple tendency of the patient to produce vegetations under all sorts of influences, the other that it is a specific bullous dermatitis. The former regard the vegetation as simply a mode of reaction of the skin under the influence of various causes; the others hold the pemphigus to be a specific disease. Each of these two theories is tenable, for pemphigus vegetans, in its typical form, has altogether the features of a specific disease, and it is none the less true that not a single one of all its symptoms belongs to it exclusively. As for the benign form of pemphigus vegetans, it has oftentimes so close a resemblance to certain polymorphous dermatitises

(dermatitis herpetiformis) of bullous and vegetating type that its existence may be doubted.

After reviewing the case published by Fordyce and Gottheil, which the writer believes accords with the *pyodermite végétante* of Hallopeau, although it has many points of resemblance with dermatitis herpetiformis and pemphigus vegetans, he refers to the case of Ferrand, which, on account of its mode of onset, evolution, and appearance of the lesions, he considers should be classed as benign pemphigus vegetans.

Constantin then reports at some length his own observation, which concerned a man of fifty-eight, of previously good health, who had first complained of intermittent pruritus, localized at first in the back, soon spreading to the whole body, but especially marked on the arms. Soon after, bullæ began to appear on the arms, and later on the legs, which were clear or slightly turbid, and left a denuded and very red surface.

These different symptoms continued for almost a month without any change in the functions or in general condition. On account of the pain from ulcerations, the patient was unable to work, and for that reason was admitted to the hospital.

The mouth had been affected from the start, where there were large patches of eroded mucous membrane separated by white patches.

With the exception of the plantar and palmar regions, almost all the surface of the body, including the face, was affected in different degrees. In the flexures, the different elements were rather more grouped and confluent, and consisted of very numerous vesicles and bullæ and papillomatous elevations of a pale red color, and exuding without being positively ulcerated. These vegetations were especially pruritic, but not very painful, and seemed to have followed vesicular bullous efflorescence, although this transformation could not be directly observed.

The writer thinks that he is dealing with a bullous and vegetating form of dermatitis herpetiformis. Under soothing treatment the affection rapidly improved, and after three weeks had almost entirely cleared up. The following month the patient experienced three successive attacks, which were preceded and accompanied by severe itching and the appearance of small vesicles. He was also affected from time to time with œdema in various parts of the body. Examination of the urine showed a marked diminution in the urinary sulphur, and the presence of indican. There was a slight leucocytosis.

The writer thinks that he is dealing with a bullous and vegetating form of dermatitis herpetiformis. The implication of the mucous membrane of the mouth and nose, the localization of the vegetating lesions in the flexures, and the slight density of the painful symptoms, would make one lean toward pemphigus vegetans.

With regard to the differential diagnosis, it is emphasized that the

multiformity may not be present at all times in dermatitis herpetiformis, and that the subjective signs of burning and itching may not appear until late in the course of the disease. (It is the reporter's belief that these symptoms have been much exaggerated in differential diagnosis.) The localization of the lesions of dermatitis herpetiformis may be similar to that of pemphigus vegetans, and it may, like the latter, affect the mucous membranes. As to the vegetation, it should be considered as a complication rather than as an essential feature, for a number of forms of bullous and pustular dermatitis may become vegetating. Unfortunately, the histology and the examination of the various secretions throws no light, and eosinophilia can no longer be depended upon as a means of differential diagnosis between different cutaneous affections.

The case of Winfield, reported in this Journal, Vol. 25, page 17, is cited as presenting good evidence of the specific infectious nature of this disease. It concerned a young girl of eighteen with an eruption strictly limited to the typical points of election, and at the autopsy severe lesions of all the internal organs were found.

Benign Pemphigus Vegetans. Ferrand. (*Ann. de Der. et Syph.* April, 1907.)

Ferrand describes a case occurring in the service of M. Darier in the Hôpital Broca, which is interesting as proving the existence of a form of pemphigus vegetans with a short and benign course. The patient was a young woman of twenty-two, with no important hereditary history. When she entered the hospital the affection had lasted about three months. It began by intense itching over the whole body, which was followd by bullæ on the legs. This condition lasted several weeks, and the affection extended to the scalp. When she was admitted, she had numerous crusts on the legs, of a fetid character, as well as upon the shoulders and upper limbs. There were very marked vegetations at the anal orifice. Some of these lesions were shallow ulcerations and covered with small papillary vegetations. There was nothing abnormal on the mucous membrane of the mouth and throat. After being in the hospital some days, however, vesicles appeared on the lower border of the tongue.

The general condition was good during the whole course of the affection, which was about four months. The eruption in some respects resembled that from iodides or bromides, but neither bromide nor iodide was found in the urine. Moreover, the moist, succulent character of the bromide eruption was not observed.

The case, therefore, was characterized by the appearance of an intense pruritus and of bullæ, which dried and left an ulcerating surface which became vegetating and crusted. The eruption was especially marked upon the extremities, and spared the face. The lesions healed

in three weeks under the influence of simple treatment, and during this period there were no recurrences, except one bulla, followed by a vegetating ulcer and a few vesicles beneath the tongue. The resemblance of this case to dermatitis herpetiformis is evident. The writer thinks, however, that the absence of multiformity, the lack of eosinophilia in the liquid of the bullæ and of the blood, and the slightest accentuation of subjective sensations would be against classifying it as dermatitis herpetiformis. He thinks, therefore, that it is possible to admit the existence of a pemphigus vegetans of benign character, and that this observation is probably an example of it. It is possible, also, that the vegetating character is only an accidental complication of different morbid entities.

DISEASES OF THE SWEAT AND SEBACEOUS GLANDS.

By Hermann G. Klotz, M. D., New York.

Elimination of Bacteria and Some Soluble (Bacterial) Substances Through the Sweat, Experimental Researches on.

A. Blumenfield, *Arch. f. Derm.*, 84, 92, 1907.

B. experimented, mostly on the cat, with Bac. pyocyaneus, B. prodigiosus, B. of typhoid and of anthrax, gonococcus and meningococcus. Fresh fully virulent cultures suspended in physiologic salt solution were injected and the sweat was gathered from the balls of the toes after producing sweat by pilocarpin and the application of heat. In no instance could bacteria which had been introduced in the blood be found in the sweat; it seems, therefore, that micro-organisms circulating in the blood are not excreted with the sweat and that the elimination of bacteria is not a regular physiological function of the sweat glands. B. concludes that the sweat glands offer insuperable (mechanical?) obstacles to the bacteria. Of soluble substances iodide of potassium was eliminated with the sweat, but fluorescin and agglutinins were not; experiments with tetanus toxines were not conclusive.

Symmetrical Naevi of the Face, Further Casuistic Contributions to the Multiple. Max Winkler, *Arch. f. Derm.*, 86, 129, 1907.

W., who has described five cases of syringoma or nevi cysto-epitheliomatosi in a former paper (*Arch. f. Derm.*, 67, 3, 1903), has added another case in which the connection of the tumor with the ducts of the sweat glands could be established without doubt.

The Secretion and the Secreting Cells of the Anal Gland of the Duck. On the Effect of the Roentgen Rays on.

Margarete Stern and L. Halberstaedter, *Arch. f. Derm.*, 85, 149, 1907.

M. St., who has studied the histology of the anal gland of the duck and of other birds (*Arch. f. Mikrosk. Anat.*, LXVI, 1905), has demonstrated by numerous experiments that these glands undergo considerable changes by the application of the X-rays. These changes at first are only functionary (decrease and gradual disappearance of the lipoid granules in the tubules of the first cell zone), but the final result is complete atrophy of the gland.

On Syringoma (the So-called Lymphangioma Tuberosum Multiplex, Kaposi). Sh. Dohi, *Arch. f. Derm.*, 88, 63, 1907.

Dohi looks upon syringoma as a new growth which originates from deformed or misplaced buds or germs of sweat glands. They are sharply defined from the surroundings and show a different arrangement of the cutis tissue. These conditions seem to prove that we have to do with growths consisting of ectodermal and mesodermal elements, which, detached from their original physiological connections, were formed as separate bodies and began to grow spontaneously and independently.

Malign Tumors of the Sweat Glands, Our Knowledge of. Richard Wolfheim, *Arch. f. Derm.*, 85, 277, 1907.

A critical review of all the published cases of alleged malign tumors of the sweat glands eliminates all, except one published by Darier. W. contends that it is essential for the proof of the origin of a cancer of the skin from the coil glands, that either a sure connection with the ducts or tubes of sweat glands can be demonstrated, or with glandular formation which morphologically can be identified beyond any doubt with normal or misformed sweat glands. Primarily the condition of the elastic fibers has to be investigated, because their characteristic arrangement around the tumor masses indicates whether we have to do with sweat gland tissue or not. The destructive character of the tumor is not demonstrated alone by the formation of solid masses of cells and the breaking through the membrana limitans, but by the transgressing of the normal limits of the glandular tissue. All these conditions were demonstrated by the careful microscopical examination of a small tumor which was removed from the cheek of an elderly woman without ever having caused any symptoms; it therefore had to be considered as a really malignant tumor of the sweat glands.

Multiple Abscesses in Infants, On the Pathogenesis of. Felix Lewandowsky, *Arch. f. Derm*, 80, 179; *D. Med. Woch*, 1950, Nov. 21, 1907.

By extensive examinations of several cases L. feels justified in stating that in these cases the origin of the multiple abscesses of infants from external infection of the skin by staphylococci could be demonsrated; it could also be proved that the staphylococci entered the infantile skin by way of the ducts of the sweat glands. Besides the abscesses there is present in these cases a superficial pustular affection, which has to be distinguished from the well-known vesicles of impetigo contagiosum. Histologically it is characterized by suppuration in and around the sweat pores, a "periporitis." Fror this periporitis a deeper abscess may originate. Some of the deeper abscesses are formed without any preceding pustules by staphylococci which (probably) have advanced into the deeper portions of the sweat ducts. These conditions suggest as a line of treatment the removal of the staphylococci from the sweat pores by the artificial production of copious sweating followed by bathing in or washing with desinfectants.

In the second paper L. confirms these conclusions and reports favorable results obtained in ten cases by such treatment. On the scalp where these abscesses very frequently occur, moist dressings of bichloride of mercury solutions were principally applied.

Granulosis Rubra Nasi, A Case of. T. Colcott Fox, *Brit. Jour. Derm.*, XVI, V, XVIII, 317, Sept., 1906.

Granulosis Rubra Nasi (Jadassohn), A Further Contribution to. J. M. H. Macleod, *Brit. Jour. Derm.*, V, XVIII, Dec., 1906.

Granulosis Rubra Nasi, A Case of. H. G. Adamson, *Brit. Jour. Derm.*, V, XI, XIX, March, 1907.

In the case of Fox, in a boy, nine years of age, on the end of the nose a small crust was observed, surrounded by a number of isolated, red, semi-translucent, deep-seated, slightly-projecting nodules, the size of a pin's head. The nodules displayed a deep apple-jelly-like infiltration when pressed on by a glass, and were indistinguishable from the classical nodes of lupus vulgaris, such as recur on scars. After the removal of the crusts and the healing of the excoriation, half a dozen small vesicles or clear cysts had arisen on the affected area. The case proved very intractable to treatment, and when the cysts disappeared, the original nodules remained much as before. Free sweating at the end of the nose was noted on several occasions. Fox believes that these miliary, semi-translucent nodular phase have also been diagnosed as lupus vulg. by others.

Macleod reports the further course of a case previously reported (*Brit. Jour. Derm*, V, XV, 1903, p. 197), which confirms the futility of

all local treatment. He also reports a new case in a boy, nine years of age, and gives a review of all cases published since 1902, but does not bring forth anything new in regard to the symptoms, the pathological anatomy, etiology, pathogenesis, diagnosis or treatment of the disease.

Adamson's case is that of a girl, nine years of age.

Hyperidrosis Nigricans. M. Ch. Audry, *Ann. de Derm.*, 1906, p. 1080, *Soc d. Derm.*

In a young man of general good health the thumb, index and middle finger of the right hand, *i. e.*, the portions of the hand in contact with the penholder during writing, showed a profuse hyperidrosis and a dark brown discoloration of the skin, which could not be removed by soap, but by alcohol. After drying the skin, in a few minutes a red color, accompanied by profuse perspiration, would appear, followed by a gradually deepening sepia color. There were no subjective symptoms. During vacation all symptoms disappeared, but returned on resuming of writing, although a new cork penholder was used.

Erythema Annulare Recidivans, A Case of. Bohac. *Archiv. of Derm. u. Syph.*, 1907, LXXXVI., 257.

The patient was a woman 38 years old who consulted Bohac for a localized annular eruption of the left cheek. Three times before she had had similar eruptions which had always begun in the same way, pursued the same course, recurred in the same situation and always came on in the fall. There were no subjective symptoms except very slight itching. The first manifestation of the eruption was a small bright red nodule about as large as the head of a pin. The patient stated that the nodule spread peripherally and that she had noticed that the borders of the lesion were always of a bright red color which was in striking contrast to the pale color of the centre, the contrast growing more pronounced with the extension and age of eruption. It took four or five months for the eruptions to reach the limit of extension, by which time it involved the entire left cheek from the lower lid to the level of the lower jaw and from the naso-labial fold to part way over the ear. As the periphery widened out the centre cleared up, the older lesions disappeared, the inflammation subsided and the normal color of the skin returned. The result was the formation of an irregular ring. Involution was marked, first, by a gradual paling, then by the formation of small broken segments and, finally, by complete disappearance without leaving any trace. The present eruption began as a small, pin's-head size, red nodule, which for three weeks remained unchanged in shape and size. Then it began to spread peripherally and, at the time of the examination, was said to be slowly but steadily extending. There had been no internal treatment. The external treatment had consisted of applications of lemon juice and a salve of unknown formula.

Examination showed on the left cheek an elliptical lesion about 3½ cm. long and 3 cm. wide, with its long axis downward. The border and centre presented different appearances. The border was ¾ mm. wide, of a bright red color, rising up gradually from the surrounding skin to a height of about 2 mm. on its outer side. The inner edge was somewhat less elevated but descended more sharply. The summit of this elevated rim was more shiny than the normal skin and showed fine, barely visible irregularities in its surface but there were no projections or scales or vesicles. The bright red color did not entirely disappear on pressure, but left a soft, yellowish red tinge.

The central portion of the lesion was distinctly depressed below the level of the rim and had a much paler, more yellowish color which completely disappeared on pressure. Its surface was covered with a very fine brawny desquamation. Nowhere was there any tendency to atrophy or atrophic scarring.

As regards the further course of the disease, the spread continued for two weeks when it ceased. Then, after remaining without change for a week, the border began to grow paler and to flatten, continuing until only reddish macules remained. These, too, then disappeared. from the lower border first and from the upper more slowly, so that two months later they were still although barely visible.

In the differential diagnosis, Bohac considered principally Menokelis (Fuchs) and a fixed, localized antpyrin eruption.

DEATH OF DR. MONTGOMERY.

Dr. Frank Hugh Montgomery, of Chicago, associate professor of skin, genito-urinary and venereal diseases, Rush Medical College, a member of the American Dermatological Association, was accidentally drowned while boating on White Lake, Michigan, July 14, aged 46.

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